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JANUARY
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# PUBLIC HEALTH NURSING

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PUBLIC HEALTH NURSING

*Editor*: HEDWIG COHEN, R.N.

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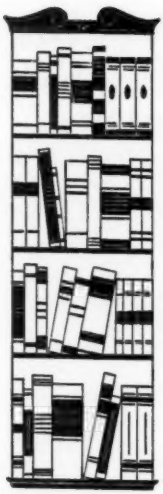

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The National Organization for Public Health Nursing is a membership organization composed of individual and agency members. Its purpose is to serve as a clearing house of information, and to develop and interpret standards for personnel and practices in public health nursing. This is accomplished through an advisory service to individuals and agencies interested in public health nursing; through publications, including the official magazine, PUBLIC HEALTH NURSING; and through connections with national, state, and local agencies in related fields. The organization is administered by an elected board of lay and professional members. Its activities are carried on by committees representing public health nursing and related fields, and by an employed staff.

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*1. Stokes, J., Maris, E. P., and Gellis, S. S., The Use of Concentrated Normal Human Serum Globulin (Human Immune Serum Globulin) in the Prophylaxis and Treatment of Measles, J. Clin. Invest. 23:531-540, 1944.*

*2. Karelitz, S., Does Modified Measles Result in Lasting Immunity? Jour. Pediat., 36:697, June 1950.*

*3. Stokes, J., Use of Gamma Globulin from Large Pools of Adult Blood Plasma in Certain Infectious Diseases, Ann. Int. Med., 26:453, 1947.*

# PUBLIC HEALTH NURSING

*Official Organ of the National Organization for Public Health Nursing, Inc.*

## Your "National" and You

MUCH HAS BEEN written and said in the past few months about the two new organizations for nurses and nursing, so perhaps now is the time to take a good look at our "national"—the NOPHN—as it is today to remind ourselves of what it does and what membership means to the public health nurse and to others also interested in public health nursing service and education. You pay dues to your national and you expect that the support which you give in this way will produce benefits for you and for public health nursing.

If you take a look at NOPHN you see ample evidence of what it has done nationally: You see how the members work together at the biennial and regional meetings, you see its publications, its cooperation with other national organizations, and its success as a coordinating center for information and for action on new ideas, problems, or trends. Locally you may see its effect on the performance and program of your own agency, but sometimes you may wonder what it does for you personally.

What are some of the things that your support of NOPHN through your membership has accomplished for the public health nurse—for her standing, earning capacity, and job satisfaction? It might be helpful to point out a few examples of what we can do by getting together and working through a national organization.

If NOPHN had not been on the job our *working tools* would not be what they are today. We follow the new methods, for example, through the articles in PUBLIC HEALTH NURSING. We improve our working knowledge and skill and find new ways of doing things by reading other publications of the organization. Consider how valuable one booklet like *Nursing for the Poliomyelitis Patient* (JONAS) can be, whether you are the only nurse in the district or one of many in a large agency. And for the executive and the administrator there are many aids to guide progress toward better community nursing service. Reports like the *Cost Study* are widely used administrative tools.

NOPHN has helped the public health nurse for the forty years of its existence with specific problems of her job. As these problems arise they receive special consideration by NOPHN committees, whose members study and report on them. For one: What are we going to do about transportation for the public health nurse? Getting around to her patients is a necessary part of her job, and saving her time in travel is good management. An NOPHN committee has been studying the use of cars for transportation and its findings will help clarify present patterns and point the way to more satisfactory practices.

Then there are the standards of professional qualifications which mean so much to us. NOPHN has said that the public health nurse shall meet certain requirements in her education and training, and has also defined other personality and leadership characteristics helpful in her job. The public health nurse has gained in personal stature and community prestige as we have worked—through our national—to raise standards.

Our security as public health nurses is also a practical concern of our national. The salary scales recommended by NOPHN have influenced representatives of member agencies, board members, and executives to see the value of improving personnel policies, including salaries. There have been annual studies of salaries and periodic recommendations

about salary scales. Looking to the future a committee is currently working on ways and means for including payment for nursing service in medical care insurance plans. And for the public health nurse needed at home in the national emergency a recent series of official statements will help in adjusting services and securing recognition for the nurse who serves on the home front.

One of the strong features of our national organizations always has been the interest and support of lay members. These informed citizens have helped public health nursing go forward, and our communities are better because of their understanding and action.

So we all have strong personal reasons for belonging to NOPHN, and we view the formation of NLA as a natural "next step" in all that NOPHN and the other national organizations have been doing. We of NOPHN have ready evidence of what can be accomplished by working together. We enjoy this partnership of nurses and others interested in public health nursing and we look forward to extending it to other professional and lay groups.

Because we are keenly aware of the value of our national we renew our membership and support NOPHN for 1952. Our membership carries with it the right to be charter members for 1952 in the new national organization, the Nursing League of America, and it also carries with it a responsibility to use our knowledge of working together to make the new national accomplish what we want it to for nursing service and nursing education in our communities.

## The March of Dimes


The first of the year ushers in the March of Dimes, which has become literally a march on polio. Nurses have a deep interest in this campaign, conducted annually by the National Foundation for Infantile Paralysis to raise funds to carry on its program to prevent and to cure poliomyelitis.

In spite of the combined efforts of scientific and citizen groups polio still presents an unhappy challenge. There were 280,500 cases of poliomyelitis in 1951. Four out of five of these individuals, many of whom are young children, have been helped through NFIP services. Many will continue to be helped during the long convalescence typical of the illness.

The National Foundation needs our dimes —and dollars, too. For the fourth consecutive year the Foundation went into debt financing the cost of care and treatment for the victims of this disease, the actual expenditure for services of nurses, physical therapists, physicians, and medical social workers and for necessary equipment being $26,000,000. The Foundation also carries on a program of vital research. The last year saw vast strides in the attempt to produce a polio vaccine. The day on which a proven vaccine is found will be a glorious one.

The National Foundation for Infantile Paralysis has announced the continuation of its grant during 1952 for the work of the Joint Orthopedic Nursing Advisory Service. In a way this is a recognition of the role of nursing in the prevention and treatment of infantile paralysis. You will recall that Louise M. Suchomel, senior consultant of JONAS, helped organize the nursing participation in the NFIP controlled experiment for the search of a serum to prevent paralysis in polio carried out in Utah last summer. There are five nurses on the JONAS staff who in 1950 and 1951 made more than two hundred visits to public health nursing services, schools of nursing, and hospitals for the purpose of improving the nursing care of patients with polio.

Nurses have a role to play in the poliomyelitis control program. Today a simple way of accepting one responsibility in this role is to join the March of Dimes.

# The $64 Question: How to Stimulate Board Members to Keep Informed

CONSTANCE REYNOLDS BELIN

AT THE RISK of being stigmatized as a "sourball" or "pessimist" I venture to suggest that many—I might even say too many—board members are apathetic about educating themselves in the field of public health nursing. They are not averse to having information or data in predigested form fed to them like pap, if someone else has ferreted out the information and put it in a readily assimilable form. But if left to her own devices, the average public health nursing board member is, I believe, reluctant to make an effort to educate herself in this field.

However, for the sanity of executive directors and officers of boards, there are welcome exceptions to the above. It is the conscientious board members who deserve highest praise not only for their own achievements in and contributions to the field of public health nursing, but also for the determined efforts they put forth to learn both the background of their subject and current developments which portend the next steps. These are the board members who by studying bills pertaining to health before their state and federal legislature, by reading nursing periodicals and publications, and by attending workshops and conferences are "up" on public health nursing. They are the answer to any director's prayer.

Sadly enough, those most sorely in need of a little sound information seem unwilling to expose themselves to conferences or workshops. They inevitably have excuses for their absence. Some fear they may be bored and so stay away. Did they but know it, once they begin to acquire knowledge of their field, it becomes more interesting and less boring with every conference attended, or each discussion heard. A little knowledge is not a dangerous thing in the primary education of a board member. It grows beyond the primary stage. Then many thanks can be given for the faithfuls who "see the light" of new trends, new methods, and new ideas. It is they who tutor their less educated sisters (brothers, too) by their enthusiasm for what they have learned. If one of your board who attends a conference can indoctrinate ten percent of her fellow board members with what she has carried home from the conference, she is a messiah.

The ones who are bored with outside meetings are also bored with the monthly meetings of their own agency, and when "heavy" matters are discussed they wear that glazed look about the eyes that betokens planning next summer's wardrobe. Let the discussion be involved with such nursing policies as rotating Sunday duty for staff members, or such agency problems as cooperation with hospitals on patient referrals, or the agency budget for the community chest, and the resisting sister is miles away. But when the executive director reports a good tear-jerking case about the destitute widowed mother of seven children, preponderantly delinquent, who is dying of an incurable disease, the bored members are

*Mrs. Belin is a member of the* NOPHN *Board of Directors and also of the Board of the United Community Defense Services. She has been closely associated with the* VNA *of Scranton and Lackawanna County, and is at present chairman of the Education Committee of the* VNA's *Board.*

instantly alert and interested. How sad a commentary on us board members that we often need the lurid to arouse our interest in the activity for which we profess deep concern.

Since the foregoing situation can be found in more than one local public health nursing organization, it seems to me that the crux of the matter is to persuade board members to *want* to educate themselves. The $64 question is "How does one persuade board members to seek education?" I do not know. It is the secret of the century as far as I am concerned.

However, there are some measures that might be tried. Many will fail. But some of them might make a few board members disposed to learn more. First of all, I believe the choice of board members is a basic consideration. If those who are known to be alert and eager to learn, with open minds, are chosen for board membership the agency is thus assured of good material to start with. Selecting a person only because of the prestige of his or her name is a waste of a membership, as well as of everyone's time and effort.

GRANTED ONE has malleable material to mold educationally, then the education of members should start as soon as they accept a place on the board. As a beginning they should be required to read and be informed about the agency's *Handbook of Information*. The Scranton Visiting Nurse Association uses such a handbook containing data on the organization of its board and committees, the operation and cost of its nursing service, the agency's place in the community, and some ideals and standards for nursing service. While members are newcomers, eager to make a good impression on the rest of the board and still filled with a sense of importance of having been singled out for the honor of board membership, this is the time to exact as much required reading and attendance at conferences as possible. This is the education chairman's big moment.

Her "longterm"—note that as an educated board member I did not say "chronic"—problem is to persuade, wheedle, threaten, and cajole her fellow board members to read PUBLIC HEALTH NURSING. By this I do not mean "leaf it through." Most general members fear this masterpiece of information will be too technical for them. "It is so dry," they moan, "you can't understand it unless you are a nurse."

This is incorrect. If board members will read the magazine they will find their minds are not overtaxed. They will discover that other agencies have the same problems as theirs and they will learn ways by which others cope with these problems. They will read of the issues that face the nursing world today. I consider PUBLIC HEALTH NURSING one of the simplest means of education for a board member. For anyone worried over the future finances of her VNA when the Metropolitan Life Insurance Company terminates its nursing contracts in 1953, Emilie Sargent's "A VNA Considers Patients' Fees" in the September issue is brimful of ideas. "Community Planning and the Handicapped" and "Rehabilitation and Nursing," both in the October issue, are goldmines of information on subjects that all public health nursing enthusiasts want to be better informed on. I repeat that the magazine simplifies the job of the education chairman, if she can persuade her board members to expose themselves to it.

The NOPHN also prepares and publishes books, reports, and leaflets to keep members abreast of developments in the world of public health nursing. Edith Wensley's *The Community and Public Health Nursing** offers a wealth of information and ideas for all board and committee members. Dorothy Rusby's *Study of Combination Services in Public Health Nursing*** is not only timely and informative when consolidation of public and private agencies is in the air, but it is also extremely readable.

No matter how many written words are placed before board members the spoken word, I feel, remains the one that "gets 'em." Therefore, attendance at regional conferences, workshops, or institutes—whatever the name—ranks high in educational value. The various VNAs in my district of the Pennsylvania Organization for Public Health Nursing take turns in planning the annual one-day institute for board members. Topics of current interest are discussed and the board

members leave the institute versed in such terms as "structure of organized nursing" or "collegiate schools of nursing." We have found that our members are more impressed by an imported speaker than by a domestic one.

I WONDER WHY board members are not held responsible for formulating an opinion or decision on study material sent them prior to a board meeting. This would be especially valuable at the end of the summer months when there had been less need for the board to meet regularly, but business had continued as usual. The president and executive director might compile a report presenting issues on which board action would be necessary and send this to the group. After studying the material the member should be prepared to give her considered opinion when called upon. At community chest budget time I feel all board members—not merely the finance committee—should be ready to discuss their agency's budget. I can think of many occasions when both the agency and the board member could benefit from premeeting study.

The board meeting is the place where the average member will receive her greatest exposure to education. By hearing discussions of nursing problems and by participating in efforts to solve these problems, she willy-nilly is infected with the virus of public health nursing. The president may assist by giving the less well informed jobs to do and thus drawing them into the fold of learners. I do not see how anyone can fail to be interested in an executive director's report or in the five- or ten-minute speech of the staff nurse or supervisor who tells of her experiences in the field in order to focus thinking on a special problem or aspect of nursing.

Therefore, to get and hold the interest of members board meetings must be so fascinating, interesting, and stimulating that no member will feel he or she can afford to miss one. This is particularly true for male members of a public health nursing board. May I inject here a plea to executive directors please to weed your reports of some of the unknown and unpronounceable terms, or translate them so that we general members know whereof you speak? "Prosthesis," "hemiplegia," and "colostomy" are awesome and suggestive of dire tidings until you acquaint us with their meaning. I notice that men on a board become irritated by, rather than eager to learn, strange terms. When they are outnumbered by women at a meeting, they act uncomfortable at the mention of obstetrical terms. Reports for board meetings can be arresting and challenging with few technical expressions.

The responsibility for interesting and fruitful board meetings rests with the president, program chairman, and education chairman. If it is a luncheon meeting, the president might eat her lunch either before or after the meeting, so that every minute can be devoted to the purpose of the meeting. I believe that routine matters such as minutes and reports of standing committees can be dealt with even above the clatter of dishes, so that when postprandial peace and quiet resume there will be time for special reports and discussions. Thus, by giving emphasis to these reports and discussions, the president steers the board members toward becoming informed, almost in spite of themselves. And once started in this process, they begin to *want* more education.

However, the real responsibility for making board members want to educate themselves lies with the executive director. I say this feeling that my professional friends may well retort, "And that's just why we get sick of our jobs. Why put that on our overloaded shoulders?" As chairman of a VNA education committee, I agree that my statement sounds like buck passing. But I am sincerely convinced that because of her position, the executive director has an unparalleled opportunity, by the bits she feeds them, to tantalize board members to learn further. She infuses them with a desire to know more about their agency's relations with other organizations in their community, and of the lacks and duplications in the overall health planning. By enlightening them on developments in the world of nursing, the director can stimulate her board members to become acquainted, for example, with the work of the Committee on Careers in Nursing and thus with Mrs. Bolton's bill for federal aid to nursing education.

IN OTHER WORDS, the executive director, already overworked in a fulltime job replete with headaches and problems, must apply what I call the velvet rock technic to her board members. While seeming sweet and docile, the epitome of the dear old-fashioned nurse, she must in reality be a driving fury whose methods in goading board members to learn for themselves about public health nursing would put Simon Legree to shame. She is the catalytic agent which sets the board member to learning more about this field. The director is a natural in inciting board members to realize how their agency's problems and solutions fit into the larger issues facing the nursing profession. It is through the eyes of the executive director that the board member sees the value of applying NOPHN's new cost analysis to her agency, and through the same medium that she visualizes the possibilities to the agency of the inclusion of nursing services in medical care plans.

I speak feelingly on this subject, for I am a product of the velvet rock technic. As such, I am daily grateful for the time and trouble our executive director took, and is taking, to open to me the doors of public health nursing. Because these women of vision with devotion to ideals have shared with me their knowledge and interest, I have an avocation that becomes increasingly satisfying to me. How can anyone adequately express appreciation for delightful contacts, interesting work, and challenging opportunities? I should like anyone who chances to read this far to know of my humble gratitude to that most wonderful of friends, the velvet rock, alias the executive director.

Furthermore, it seems to me that the executive director is by her position *the* person to indoctrinate her board with concern not only for local issues but also national ones, such as the Nursing League of America, the Biennial Convention in Atlantic City in June 1952. And this indoctrination will pay dividends, for once a board member has become imbued with the desire to learn more about public health nursing, she will find it thrilling, stimulating, and capable of setting off chain reactions. She will never again be content to be uninformed in the field of her choice, but will seek to know more about it. When the board member begins to wonder why there are too few public health nurses, she will inquire into recruitment; from there into nursing education; from there into federal aid to nursing education and into accreditation; to the university school and its degree program; then to the local hospital school of nursing. Here she finds herself in her own community and is faced with her responsibility as a citizen for this whole subject.

It is an endless sequence. The result is that no matter how hard one studies, one can never become fully educated in the field of public health nursing. This is as it should be, I feel, for nothing as great and stimulating as this subject should be a handy capsule, complete in six easy lessons. It is too valuable and too vast to be cheapened by easy attainment. Robert Browning in "Andrea del Sarto" expresses my feeling about the education of a board member in the field of public health nursing:

> Ah, but a man's reach should exceed his grasp,
> Or what's a heaven for?

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* Wensley, Edith. *The Community and Public Health Nursing*. N. Y., Macmillan, 1950. See especially chapter 14, "Keeping Informed."

** Rusby, Dorothy. *Study of Combination Services in Public Health Nursing*. N. Y., National Organization for Public Health Nursing, 1950.

* * *

> . . . Analysis is like being wrapped in a protective cocoon of gentleness, permitted to find a safety I never knew. It was an experience through which I lived, comparable to growing up again. It was like receiving painless injections of love and trust which gave me the strength to accept myself.
>
> —From *Fight Against Fears* by Lucy Freeman

# A Staff Nurse Looks at Supervision

M. KATHRYN BERBERET, R.N.

BY THE TIME I finished my public health nursing course at the University of Oregon Medical School I had decided that I wanted to work in a health department with a fulltime public health physician, a fulltime nurse supervisor, and a medium-sized staff of nurses. I also wanted to work in a department which carried out a generalized public health service, was well known in the community, and which served all people. I wanted to work with a congenial and friendly group of people. I desired fulltime supervision because I wanted guidance and direction in my work activities. This was a big order.

One of the best ways to find such a health department is to start looking. Within the next six weeks a friend and I traveled through four western states and visited several different agencies. Financially this would have been difficult to do if we hadn't looked up friends and relatives along the way whom we hadn't seen for years.

When the journey was finished it wasn't hard for me to make my decision. In fact, I really think that it had been made before I left Jackson County, Oregon, although I didn't want to admit it because I wanted to visit the other departments with an open mind. So I wrote to Jackson County Health Department saying I was interested in a position. As the department was short of nurses at that time I was employed immediately. Today, after working a year and a half in Jackson County, my expectations have not only been fulfilled but I am just as happy and satisfied with my decision as the day I made it.

These are the reasons: to begin with, I was received with so much friendliness that I felt at home right away. The staff was not only interested in securing a new nurse but the members helped me get settled in an apartment and even loaned me furniture.

The first few days were devoted to an extensive and thorough explanation of the department policies and administrative procedures. A description of Jackson County, the problems of the various communities, the occupations of the people, helped me to understand the health problems which would confront me. My supervisor made home and school visits with me until I was better acquainted and could carry on alone. We discussed the health problems as we met them. Because this was done on such a friendly basis and with such ease, I welcomed this supervision. I had the feeling that I could express my ideas quite freely—and I did. When I made mistakes it seemed as though they were taken as a matter of course. They were handled with understanding and by explanations of how the situation could be cared for more smoothly. I really appreciated this and I still do.

Although we have certain specified programs to carry out in each of our communities we are allowed freedom in developing programs in which we are interested. For instance, in Jacksonville, which is the oldest settlement in Jackson County, there are many elderly retired people whose lives are just wasting away. Because I am interested in geriatrics I thought that this would be a good

*Miss Berberet is on the staff of the Jackson County Health Department. She presented this paper at the* NOPHN *Regional Meeting in Portland, Oregon, in May 1951.*

place to develop some sort of a program. Just this spring several people told me they felt something should be done for the old people. They see the need. Gradually more people are becoming interested. Maybe in a year or two, with everyone working together, a program will be in operation to help the old people. Because I do not have to stay within a certain range of work, I can go ahead and help in this development.

OUR WEEKLY staff conferences seem to tie together and bring into focus what we are working toward. Everyone talks and we learn much from the valuable information contributed by each member of the staff. I wish I could tell you just how interesting our group discussions are. The supervisor and the staff plan them together. Last fall we discussed the subject of how we could get the most out of these conferences. Because everyone speaks her mind we hear quite a variety of ideas. I learn a lot from these about how to solve family problems because practical solutions are offered along with them. Department policies are talked over as well as ways in which they might be carried out in the communities. We invite speakers from various agencies to give us ideas about how to help families by using their services.

One day last week a lady who lives thirty miles from Medford, the county seat, said to me, "You know, the health department does more for Jackson County than any other part of the county government. We seem to know more about what you do. You give us so much good information."

On the way home I thought about this. I think these are the reasons why she spoke as she did: Over the years public health has been practiced in every community and outlying area. Help has been given when help was needed. The whole department has worked together to give as much service as it could to all the people. I learned this from the people themselves. Members of the staff are represented in community activities and belong to clubs. People become acquainted with them and their work in this way. The health department is regarded as an authority on health problems. We work closely with the private physicians. The staff is friendly. We help each other with our work. We all get along very well together. After thinking over all these things I feel that much of this is a result of the examples set before us. I call this good supervision.

Although we know about the administrative problems, such as the budget, the staff nurses do not have to worry about them. Our health officer takes care of this.

Our supervisor paves the way for us in our work with people of other professions. For example, last spring we felt that our school program was not so successful as it could be. Many new teachers did not know how to use our services to the greatest advantage. Our supervisor and health officer planned a meeting with the school principals and superintendents to discuss the problem. The director of the Maternal and Child Health Section of the State Board of Health was invited to give us guidance. Merely getting together and talking over the problem seemed to help clear the air. This winter we thought the schools used our services more effectively by referring children who really needed help. Could this have been done so well without supervision?

We discuss our problems and ask for help from our supervisor when we feel the need. She takes a personal interest in our work. Because she is a fulltime supervisor, she is easily available when we want to talk with her. The supervision we receive is a continuous process. It is carried on in each phase of our work. No matter what activity we are planning there is someone to turn to for guidance. Such an adviser has sight of the whole program, which we are apt to lose track of at times. With good supervision our work becomes educational to both nurse and patient. We plan for the future as well as the present.

I got what I wanted when I started to work for Jackson County Health Department!

# Recording Talks for Group Work

L. EVELYN SCHOLL, R.N.

SHORTCUTS ARE welcome in this busy world in this age of speed and they are especially welcomed by a busy nurse. In our town, Neenah, Wisconsin, we have been experimenting with conducting teachers' meetings via dictaphone recordings. Other nurses may find it helpful to do something similar in their work.

There are nine schools in Neenah and this year our superintendent of schools recommended that the specialists—music supervisor, physical education instructor, speech correctionist, and nurse—hold group conferences with the teachers in their respective schools in the mornings from eight to nine o'clock or in the afternoons from four to five. The teachers accepted the suggestion with enthusiasm. However, it meant considerably more work for us all, since instead of each one of the specialists giving just one talk, we all had to give nine. Where, oh where, was the time coming from?

I am city and school nurse in Neenah. I have no regular office assistant and at that time my desk was piled high with unfinished reports and records. One day when I was wondering how I was going to fit these eight meetings into my busy schedule an idea came to me: Why not try presenting my material to the teachers by use of a dictaphone record? We have a combination dictaphone which may be used as a recorder or transcriber. It has a loud speaker and also a silent stethoscope listening device so that it may be used for group work or for office transcriptions.

We all know that education is a process of repetition, a repeating of the "same old stuff" in new and different ways. Certainly the dictaphone would be a novel way of presenting information, and it might be fun. So I decided to try it, especially since it seemed to me there were quite a few advantages in the method: (1) it would save time and money (2) it would assure presentation of the same data to all the groups (3) it would give us an opportunity to review subject matter for future reference, prevent duplication, help us study progress, and understand our problems better (4) transcribed copies could be made for interested groups (5) it would give the narrator an opportunity to listen to herself critically and seek improvement in voice control, diction, et cetera, if indicated.

So I dictated my first talk to the machine. I was then free to do one of two things: I could send the machine and record to the meeting and ask one of the group to introduce my material, or I could accompany the equipment, start the record, and sit back on the side lines with the teachers and listen. When I attended meetings I explained why I decided to use a record. There always is a good deal of interest in this. In fact, the method itself is attention-getting. The teachers keep their comments and questions until the record is run through. Then a brief period of discussion, which also is recorded, follows. This is then played back and is greeted with chuckles and comments. "Why, my voice doesn't sound like that! Or does it?" New interest and an element of surprise enter the picture.

My first experiences were enjoyable. I sincerely believe my idea has "paid off." I can cover more ground more thoroughly in shorter time than previously. People are interested in the procedure and listen attentively, although sometimes the material may be familiar to them. Maybe you, too, can use this technic in some aspect of your work.

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# Accident Prevention

## A rural public health nurse considers preschool child safety

ADELAIDE B. CORSON, R.N.

ANYONE READING the evening paper on the day this article is being written would note with interest and concern two news stories. "Diet Rough on Baby," the first one reads. A three-year-old, thinking his two-month-old-baby sister was hungry, fed her a bottle of toilet water; doctors say she will survive. "Fall Victim Reported in Critical Condition," reads the second. A two-year-old tot fell fifteen floors from an apartment window, and miraculously lived. Yet the same reader, even I, a public health nurse, might glance at the words, "accident prevention," think "That is a matter for motor vehicle bureaus," and turn the page. All too long have public health nurses been oblivious to the importance of this problem and to the great opportunity we have to play a decisive role in accident prevention for the infant and the preschool child.

### A challenging problem

A glance at the statistics would awaken the most lethargic, as it did me, to the fact that accidents have become a number one health problem among young children. It is true that the preschool group may be termed a *relatively* safe group as far as accidents in general are concerned. In Connecticut in 1949 the accident death rate for the age group 1-4 was 23.8, third lowest of the ten groups listed.[1] And it is also true that considerable progress has been made in accident prevention. Connecticut statistics are again representative in showing that the decline between 1922 and 1947 in accident death rates for children in the age group 1-14 was 73 percent.[2] Yet these heartening facts must not be allowed to hide the grim truth; accidents kill more than 12,500 children in one year. As progress has done much to eliminate other causes of death in childhood, accidents, by default, have become the leading cause of death in the young child. More children between the ages of one and fourteen are killed by accidents than by any one disease, as many as are killed by pneumonia, diarrhea, enteritis, measles, diphtheria, meningitis, poliomyelitis, whooping cough, and scarlet fever combined. For each accidental death in the home, there are an estimated one hundred fifty disabling accidents. When we consider that probably 90 percent of all these accidents are preventable we realize that here indeed is a problem and a challenge we cannot overlook.

The public health nurse, whose work centers in the home, is well situated to work constructively with the problem of preventing accidents, especially among infants and preschool children. Consciously or unconsciously in her routine work she is already doing much in safety education. Beginning with her first visit to bathe the newborn baby she teaches accident prevention. She cautions the mother to close the safety pin, to test the temperature of the bath water, not to leave baby

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untended on his bathinette or bed. During her subsequent visits she may make many spot safety suggestions as the opportunities arise: a toy is left in a dangerous place, a pot handle is within a toddler's reach. She is called upon frequently to give first aid and this offers ideal opportunities for safety teaching. The alert public health nurse almost instinctively incorporates these safety points into her everyday routine.

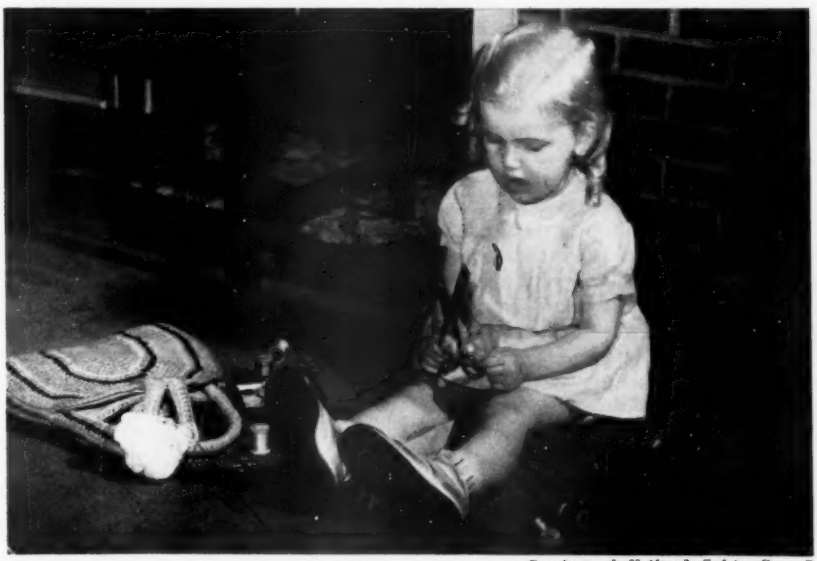
Excellent beginning as this is, it is obviously not enough, as the statistics show. We must all ask ourselves, "What more can we do to prevent accidents to children?" I consider particularly what I, a rural public health nurse, can do for child safety.

#### Securing information

To begin with, we must know the facts. Only if we are informed on the subject and vitally concerned with the problem can we convince others of its importance and thus secure results. The nurse who has been unsuccessful in impressing a careless mother with repeated halfhearted warnings, "He might fall off the bed," may get some results if she knows and takes time to explain the facts and helps the mother realize how important accident prevention is in the total care and protection of her child.

How can we learn the facts? The individual nurse, as well as the agency, can best begin by doing a little research on the subject. There are excellent sources of information: state health department bulletins and releases, pertinent articles in current medical and nursing literature, special publications of the National Safety Council, the Federal Security Agency, the U. S. Department of Labor, and insurance companies, among which the Metropolitan Life Insurance Company is outstanding. A valuable collection can be compiled containing statistical material, magazine reprints, pamphlets, and checklists. Such a file serves a dual purpose in interesting and educating the nurse and in providing illustrative material for teaching in the field.

With this material to use as background the nurse must acquaint herself with the subject of child safety, and define her own personal relationship to it. In large agencies safety education may have an established place in the inservice education plans. The rural nurse, often working alone, must seek knowledge through her own efforts; she must collect local statistics and study her community's



*Courtesy of National Safety Council*

needs. Then she must evaluate her program in relation to the contribution she is making in the safety field, especially her contribution to child safety.

## Public health nurse's contribution

Armed with increased awareness and greater knowledge the nurse will be able to go into the home and guide parents to see the importance of the problem. From the many checklists and pamphlets available she should select the ones most applicable to her community, and from the beginning of her contact with a family incorporate safety education as automatically as she does other phases of public health. Safety pamphlets, checklists, and written baby-sitter suggestions should be discussed and left in the homes visited as routinely as printed directions on other aspects of baby care. Teaching of accident prevention should be as natural as teaching of immunization. Dr. Press[3] points out to good effect the similarity between the two, for by safety measures we hope to "immunize" against accidents, and he suggests that at well child conferences and in the home when immunization is discussed emphasis on safety measures may very logically be made.

The public health nurse who has interested herself in this problem will find that in many indirect ways she is making a contribution to the cause. She will have increased her awareness of opportunities to teach; safety hazards which would previously have gone unnoticed in her visits to a home will cry out to her to be corrected. And she will find that she is, in everyday living, a better safety example. This is important when it is remembered what great imitators children are. It is even more important in the rural community where children and adults alike are extremely aware of the actions and attitudes of the nurse, both on and off duty.

### Index person

Another way in which the public health nurse should make a contribution is by an increased awareness of *the need for awareness* not only of actual hazards but also of activity going on about her during her visit, and her responsibility. Dr. McIntosh[4] states that four fifths of preschool child accidents are due to errors of adults. Distraction is probably an important factor in many such errors. There is a subtle aspect of divided responsibility when another person is the distracting influence; when two people watch a child the first one unconsciously relaxes his vigilance, and an accident may occur. When the second person involved is the public health nurse the other individual is even more likely to transfer her responsibility because of her confidence in the professional person. The nurse's presence at an accident may provide good opportunity for safety instruction as she gives capable first aid, but it is far better safety teaching if she unobtrusively considers potential dangers on entering the home, observes that the child is dangerously close to tugging the table scarf and potted plant down upon his head, and warns the mother in time to prevent the accident.

The scarf-pulling incident or a similar one may provide the opening for the nurse to get across to the parent the idea of the dangers of divided responsibility. Chapman[5] calls this idea the "selection and education of the 'index' person," and says that the technic is a new one. The principle, however, is as old as a well developed mother instinct. Every nurse has seen it at work in the capable experienced mother who, in spite of conversation and other distractions, is alert to each motion her child makes and again and again casually rescues him in the nick of time from impending disasters. It is our job to try to help the new mother understand the need for this continual responsibility, to accept it, and thus become the index person for the protection of her children.

## Mental hygiene aspects

One of the most important aspects of child safety, the mental hygiene aspect, must also be considered. This is a comparatively new approach. The literature of the Metropolitan Life Insurance Company emphasizes this aspect, and one authority has stated: "It is . . . obvious that additional research to determine mental and emotional causes of home accidents is essential as a basis for a more complete and constructive home safety pro-

gram."[6] Much is yet to be discovered in this field. The nurse, to make her best contribution, must be aware of new developments as they arise.

Everything the well trained public health nurse is doing to help parents understand their children, not only their physical development but their intellectual and emotional limitations and growth as well, is a contribution to accident prevention.

#### A child's limitations

The professional person may fail to recognize how much help parents need in order to realize their children's limitations. New parents, often coming recently from an exclusively adult world, sometimes have difficulty in thinking of this newcomer in the family as a child, but consider him a miniature adult. His physical limitations are most obvious to them, yet often they need help in understanding the safety implications of his physical immaturity—that he cannot move or react quickly enough to avoid a burn, a bang, or a stumble. They watch with pride and patience as the child learns to catch a ball, yet often need help in understanding that this very same slowness of physical development creates a need for greater protection.

For the same reasons parents often fail to comprehend their child's intellectual limitations as they pertain to safety. Adults naturally see things from the background of their own experiences and it is difficult to remember that a child lacks the maturity of judgment which has come to an adult only through years of experience and intellectual growth. The nurse who can help parents in this difficult step of parenthood will help them better to insure their children's safety.

In the first months of a child's life the parent who understands the limitations involved in the child's immature development will maintain a continual watchfulness over him. Statistics of the high accident death rate during the first year have been questioned, some authorities stating that many deaths listed as caused by suffocation are in reality caused by acute respiratory infections. Whichever is the case the same principle can apply to help reduce this high infant death rate. An informed and alert parent would detect both the danger of smothering and the slight change in the baby's condition which might forewarn of an acute respiratory illness or distress.

The nurse is here, however, faced with a problem: how can she help parents develop this extreme watchfulness without making them overly apprehensive about the dangers of childhood and overprotective after the child develops beyond the stage when complete protection is needed? As Dr. Dietrich[7] has stated, "a theory of accident prevention which embraces a changing reciprocal relation between protection and education seems needed in work with children." The nurse must use all her knowledge and ability to help parents obtain an understanding of their child's development and needs. There is the story of the lost cow which was found by the village idiot when all others had searched in vain. When asked how he found her, he answered, "I thought where I'd go if I wuz a cow, and I went there, and thar she wuz." Somehow we must help parents to this absurdly simple, yet difficult-to-obtain, solution. If the parent could continually think what he would do if he were a child, with his child's specific limitations and could act accordingly to protect and to educate as the child's age and needs dictate, many accidents would not occur.

The question of the child's emotional development is even more difficult for the nurse to help parents understand, and is far too extensive a subject for this discussion. One aspect is of vital importance to safety: the question of discipline, and its relation to emotional security. The literature on the surface may appear to be contradictory. Dunbar[8] and Whyte[9] cite the evidence of strictness in the upbringing of accident-prone individuals, and mention "resentment of authority" as a consistent characteristic. Yet Dietrich[10] on the other hand states that discipline is an "indispensable tool of any juvenile accident prevention program."

As we go on we see that there is not a contradiction here. Dietrich's treatment of the subject is helpful. His theory is that mild, consistent, and logical discipline is necessary for physical and emotional security. The

nurse who has bathed a newborn baby may have noticed a symbol of this truth. The infant on being unwrapped and being able to stretch out its arms to the limit and feel no longer the encircling blanket, so like the walls of the womb which he felt until birth, will cry out with fear. If the nurse merely puts out her hands and gives him something to push against the feeling of security is maintained and the baby is less likely to cry. This basic primitive need for protective walls is carried throughout life. The nurse must show parents how discipline can be used partially to meet this need.

Care must be taken not only that discipline is mild, consistent, and logical, but also that it does not interfere with the child's development. A child needs to express his individuality, and should be given as many opportunities as possible to make choices and express himself without endangering his safety or violating the rights of others. The two-year-old who has been able to decide many things, such as which of two toys he will play with, will develop more normally and will be less inclined to revolt against the rules which are made for his health and safety.

#### Introduction to safety

Safety rules should come gradually, one at a time, first those which pertain to dangers it is impossible to remove. For instance, one can say, "The stove is hot." A certain amount of calculated risk can be used. The child can actually be shown that it is hot, and that heat can be uncomfortable. Yet this method must accompany and not be substituted for the unquestionably accepted rule of the wiser parent. There will be many rules which the child might question, not being able to understand their need because of his immaturity. If certain safety rules have been laid down as the need arose, matter-of-factly, without questions—"We never play with matches"; "we always look both ways before crossing the street"—he need not be convinced by argument of the wisdom of each new rule.

Thus we see that the mental hygiene aspect of child safety has many facets. A child should be allowed a satisfying amount of freedom to express himself in a loving and understanding environment. His emotional, physical, and intellectual growth should be understood by his parents. Time and patience should be used to help him learn to live safely with the potentially dangerous forces of our presentday life. If this has been the case the child will be less likely to become accident prone; he will have little need to revolt against safety regulations but will, on the contrary, derive a sense of security from them.

### Summary

When we consider the problem of preschool child safety, as public health nurses we cannot help realizing that we are faced with a challenging opportunity. Even in a rural community there is much that can be done. First we must know what it is we are dealing with, and if we do not have the advantages of a large agency's inservice training program we must learn the facts as best we can through our own individual study of all the material we can collect. Then we must examine critically our own program to determine its contribution to child safety, and see how we can improve it. We must consider two simultaneous approaches. We must take every step possible to help families eliminate those physical factors of agent and environment which are involved in child accidents, and through a constructive mental hygiene program help parents to understand their children better—their physical, intellectual, and emotional limitations and needs—that they may grow normally and learn to live safely within the restrictions our environment imposes upon us. A successful program with this dual approach should result not only in a reduction in the number of child accidents, but also eventually in a reduction in the number of adult accidents and of accident-prone individuals.

Once having developed a sound understanding of the problem and a constructive program for prevention of child accidents the public health nurse should not stop there. Coordinated community action will be needed if the problem of accidents in childhood is to be conquered. In the rural community the public health nurse may be the logical one to

spearhead such extensions of her own child safety program.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* Address given as part of the symposium, Accidents, Childhood's Greatest Health Hazard, at the joint meeting of the American Academy of Pediatrics and the National Safety Council in Chicago, October 1950. Reprint of symposium papers available from the Metropolitan Life Insurance Company, One Madison Avenue, New York 10.

The Metropolitan Life Insurance Company has prepared a suggested outline of units of study in accident prevention which will be published in an early issue of this magazine.

## Alaskan Ingenuity

STANDARD autoclaves or similar sterilization equipment are out of the financial reach of many Alaskan Health Centers and nurses have been casting about for some less expensive means for sterilizing delivery packs and other supplies and equipment.

While operating their portable electric oven at home one evening several nurse consultants of the Health Department had a new idea: why wouldn't these little ovens, mounted on their tightly closed porcelain cabinets, serve as both sterilizers and storage space for sterile supplies? On a trial basis one was set up in the nursing division quarters. The nurses found it proved adequate for their purpose. Steam penetrated to the innermost folds of even dense articles such as the delivery packs. The necessary high temperature could be maintained for the required time. The steamed packs could be dried in the oven without handling.

Like most inventors the nurses attempted to carry out their experimentations on the quiet, so were loath to make inquiries about the electricity current load in the office building. Their first efforts resulted in blowing the fuse and "blacking out" the entire building. Warning: don't plug in your electric oven on a circuit carrying a capacity load!

From *Alaska's Health,* October 1951

# Have You Met the Parasite Family?

MILDRED L. CHAPMAN, R.N.

CERTAIN TYPES of intestinal parasites are commonly known in specific regions of the United States; there are others with which public health nurses are becoming familiar through many different kinds of experiences.

The extent of the problem of intestinal parasites in the United States is a matter for conjecture. Data are being collected in various areas. Study of these diseases gained momentum with the advent of World War II. Since then there are indications of a wider spread due to a great many circumstances. The war, reaching the most primitive peoples and the most isolated outposts, caused considerable redistribution of the populations of the earth. Troops, assigned to tropical regions, were introduced to intestinal parasites previously unknown to them; and with the movement of these troops, the infection was spread to regions relatively free of the problem. Devastation in wartorn countries forced groups of people back to a more primitive type of living and created mass problems.

Because of these conditions and the universal instability of economic conditions there has been a largescale movement of many population groups. Many people have come to the United States, and although the larger cities have been the focal points of settlement most communities have been affected to some degree.

Although Puerto Ricans are not a new population group in the United States there has been an increase in migration from Puerto Rico since the end of the war primarily because of the economic situation on the island. New York City has been the destination of many arrivals from this tropical island. With some general dispersement to all parts of the city and neighboring communities concentration of the Puerto Ricans in core areas continues. A number of these families have come to a Family Health Service with which the writer is associated for help with their multiple health problems. In general they have represented the low or marginal income groups whose past living experiences have left many blemishes on their health picture. One of the factors which clouds this health picture is the problem of intestinal parasites.

There are a number of intestinal parasites which are described as quite harmless. Parasites with more serious implications with which the Family Health Service has been concerned because of the relatively high number of infected individuals in its caseload are endamoeba histolytica, hookworm, schistosoma mansoni, and ascaris.

Familiar to many, amebiasis, caused by the endamoeba histolytica, is quite easily contracted and the possibility of recurrence can remain a threat for years. This particular parasite may be found in those who have never visited the tropics and may never have left their immediate community. Individuals have amebiasis without being aware of it; it can cause a latent infection. Amebiasis is more or less a universal disease. Improved diagnostic methods and greater focus on case-finding technics are helping to locate those infected.

One of the most common modes of transmission of the amoeba is through some channel of the food handling process. The term "food handler" applies to individuals in many fields—housewives, kitchen help, cooks, maids,

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waitresses, countermen, butchers, bakers, grocers, icemen, soda fountain attendants, lemonade vendors, food peddlers. Even friends and relatives can be food handlers and may pose the most difficult problem. In tracking down the source of exposure and reexposure to amebiasis sometimes the "Philadelphia lawyer" in reality is needed as a whole chain of circumstances may have to be uncovered and examined.

Illustrating this point is the story of the T family who requested family health service shortly after its arrival in New York City. Composed of eight members this family presented numerous health problems which included tuberculosis, club feet, and scabies. However, for the purpose of clarity these particular problems will be eliminated from this discussion. As part of the general plan of health supervision several members of the family were referred by the public health nurse for investigation of intestinal parasites. Stool examination reports of several members were positive. Although the father took the major responsibility for taking the children for treatment and follow-up care, he himself was loath to accept a stool examination, knowing that if the results were positive his employment would be jeopardized. Finally when his stool was examined his fears became a reality. He submitted to several courses of treatment, and the reports fluctuated from positive to negative. He returned to work only to leave again when a positive report was noted in subsequent examinations. As all other members of the family had had repeated negative reports for some time the source of Mr. T's reinfection was a mystery. The physician and the nurse had several conferences. When all other avenues had been carefully checked we were left with the strong suspicion that he was being reinfected with amebiasis at his place of employment, and this is far from a remote possibility. Eventually his employer refused to reinstate him.

As a stool examination is not a prerequisite to employment his coworkers, unaware of their own responsibility, are no doubt still serving food to the public. This has implications for the fields of epidemiology and industrial nursing.

HOOKWORM IS acquired when surfaces of the human skin come in contact with contaminated soil in tropical countries. Eventually the hookworm attaches itself to the walls of the intestine. Heavy infestations can cause marked anemia as demonstrated in the S family. It was the father who came to the office asking for help because his children seemed pale and tired in contrast to other youngsters who romped in the streets. He described symptoms which clearly indicated a need for parasitic examination. Every member of the family was found to have hookworm infestation. Three of the children, aged nine, ten, and eleven years, had hemoglobins of 62 percent, 44 percent, and 80 percent, respectively.

Quite often ascaris infestation, most prevalent in young children who eat contaminated food or drink with unclean hands, makes itself known in a dramatic way. This is illustrated by the following example in another family. The parents complained that their seven-year-old boy, ill with fever and a cough, had difficulty in breathing. He was referred by the nurse to a neighborhood clinic where medication was prescribed. A few hours after taking the medicine a severe attack of vomiting occurred—vomiting of worms! This led to his admission to a bospital, where he was found to have hookworm, amebiasis, and shigella.

At the same time the nurse arranged for the mother, who showed marked signs of malnutrition and weakness, and another child, a girl aged four, with severe diarrhea, to be admitted to the same hospital. Subsequently all six members of the family had stool examinations; all of the stools contained hookworm eggs, two showed endamoeba histolytica, and two, ascaris eggs. The potentials for good health in the children in this family have been adversely affected by these parasitic infestations and episodes of illness which have already stunted their growth and development and left their bodies in such an impoverished state that they may never enjoy good health in spite of efforts to help them attain it through camp experiences, convalescent care, and special nutrition services which included vitamin therapy.

Schistosoma mansoni, also known as bil-

harzia, has appeared less frequently in families known to our agency. It is, however, a devastating parasite because of its effect on the vital organs of the body, specifically the liver. A patient with schistosomiasis cannot enjoy a full measure of good health. Schistosomes have been known to live within the body for fifteen years without acute manifestations appearing.

Intestinal parasites may lie dormant for many years without acute symptoms of parasitic activity or without their presence being recognized. Therefore, the clinical picture is often clouded. When an individual is ill symptoms may persist, and even though much medical exploration takes place the diagnosis may remain baffling.

Some years ago a middle-aged couple with a young invalid daughter requested help with some plans for the girl's medical care. Mr. S's health history and general appearance prompted the nurse to offer him an appointment in our Health Examination Clinic as our health service is offered to all members of the family. He readily accepted. Extensive follow-up work was successful in helping Mr. S obtain dentistry and glasses. Emphasis was placed on nutrition teaching, especially to acquaint him with the elements of a well balanced diet, but his malnutrition remained a constant factor. Once he had a marked bronzing of the skin for which he was hospitalized. When his color improved he was discharged; no definite diagnosis had been made, and the results of tests had been negative. He continued to attend clinic but there was no marked improvement in his emaciated appearance. After a lapse of two years an alert public health nurse, familiar with his native land, upon evaluating service to this family and reviewing the history, referred Mr. S for a stool examination. His problem all along had been schistosomiasis. After he was treated for a period of months his general condition improved; however, the heavy infestation of schistosomes no doubt has resulted in permanent destruction of tissues within his body.

As part of the life cycle of the schistosoma is spent in a certain type of snail in tropical waters, it is relatively impossible to become infected in the United States unless the potential snail host gains a foothold here. Our objective is to locate individuals who are harboring these parasites and encourage treatment. In most cases correct and completed treatment leads to permanent cure.

There have been comparable problems in treatment of patients when amebiasis was in reality the hidden factor in the tug of war between the patient and good health. Such an experience summarized in a recent issue of *Seminar** describes the history and treatment of a man who was found to be suffering from an amoebic abscess of the lung.

BEHAVIOR OF persons with parasitic infestation is an area of study. We think of Carmen, a most unhappy four-year-old who stood or sat in the corner twirling a lock of hair, sucking her thumb, or pulling her ear. She appeared to be mentally dull. Intestinal parasites, ascaris, and endamoeba histolytica were found in her stool specimens. Carmen was treated and today, three years later, presents the exact antithesis of the first picture. She has emerged as a personality with a charm which captivates teachers and friends. After one year of schooling she is in the third grade and is teaching English to her parents.

A casework agency working with the problem of aggression in a fourteen-year-old boy who kicked his sister and mother in fits of rage referred the family to us for health service. Later, found to have schistosomiasis, the boy was medically treated and then sent for convalescent care. There are other factors to be considered in this particular situation. However, his behavior is improving.

Three other adolescent boys in each of whom truanting was a problem and who were described by parents as "hard to handle" were also found to have schistosomiasis.

An emotionally disturbed thirty-nine-year-old man was for a period of years under constant observation in several hospitals for visual complaints, gastric distress, and urinary difficulties. Later referred for a stool examination he was discovered to have schisto-

* The patient complained of pain in chest. Clinical Conferences Case 79. *Seminar*, Sharp and Dohme, Philadelphia, May 1951, v. 13, No. 2.

somiasis and was successfully treated.

The incidence of intestinal parasitic infection in the population is related to the level of sanitation of the area and is also directly related to the concept of sanitary living. When people lack this concept and live under primitive conditions the cycle of infection and reinfection is perpetuated. Untreated sewage, seepage from contaminated soil, and indiscriminate disposal of human excreta in open places where privies are either lacking or inaccessible are factors in the spread of disease. In some countries human excreta are used as fertilizer, thus contaminating raw foods. Flies and roaches are classed as major carriers of some parasitic diseases. Ignorance and neglect of personal hygiene are other factors which contribute to the spread of disease.

Dr. Frederik Van Assendelft of the Tropical Disease Diagnostic Service, New York City Department of Health, states, "At least one third of the Puerto Ricans who are here for a period of less than one year have endamoeba histolytica. More than three percent of the whole Puerto Rican population here less than five years are probably infested with schistosoma mansoni. Intestinal parasites of some kind occur in from 70 percent to 90 percent of the Puerto Rican population who have arrived recently in the New York area."

The public health nurse in the casefinding program is one of the key members in a health team. In her visits to the family she becomes familiar with its way of life, has a knowledge of its health and sickness experiences, and sees the members of the family as individuals and their relation one to the other. Associated with sickness situations and concerned with health the nurse is placed in the position of confidante to a family. She is often asked for help with problems beyond the realm of her own skill and must act as a coordinator or liaison between the family and other agencies in the community.

Success with this aspect of our program—casefinding of tropical diseases—involves many factors. The nurse's interest in people is obviously the first prerequisite. But that interest must extend beyond sympathetic listening, for the nurse who works successfully with any group must possess a sociological viewpoint gained through study of the group she is serving. For example, knowledge of the Puerto Rican culture cannot fail to give the nurse a favorable impression as well as challenge her to help those of this group who have so many health needs.

Much of our experience has been derived from continued association with Puerto Rican families, those who speak English as well as those speaking only their native tongue. Spearheaded by staff members who are familiar with Spanish culture, speak Spanish fluently, and know native phraseology, the program has gained momentum. In the community in which we serve our "open door policy" has been a buffer in counteracting some of the Puerto Ricans' suspicious attitudes aroused by the unfavorable publicity which they have received since coming to this country. Satisfied customers have been our best salesmen. We have found that Puerto Rican families are interested in health improvement, which is the main focus of a family health service.

Our success has hinged primarily on the interest of our staff, some of whom have been motivated by those members of the staff more familiar with parasitic diseases. Some nurses needed a longer orientation period to gain interest and then develop the skills and technics necessary to work with these people and their particular health problems. Giving the patient support during the treatment course requires knowledge and skill. Some parasites may resist treatment. The "obstinate carrier" needs special encouragement. Reinfection or recurrence of the individual's own infection is possible. The ideal period to review with patients the rules of personal hygiene in order to avoid reinfection is during the course of treatment.

All of our nursing efforts could have failed if the proper atmosphere for treatment had not existed. Two specialized clinics are available in the community. The skill of the detection methods of these laboratories has been proven again and again. The teamwork concept at work here embraces the patient and other members of his family, the physician, the public health nurse, the laboratory technicians, and the clerical personnel. There are

frequent conferences for coordinating information and clearing plans among various members of the community team in this learning and sharing experience. The attitude of all the clinic personnel is reflected in such communications as these which come to the nurse: "Maria didn't come for her recheck today," or "Jose is now negative and can go to camp," or "We have arranged Mrs. R's treatment so that she will not lose time from work." Physicians in these specialized clinics have unquestionably stimulated our interest in this aspect of public health.

As we have had little experience with tropical diseases there has been much to learn, and we have shared with neighborhood physicians our knowledge gained from working with these families. The staffs in the general hospitals are developing more interest and are becoming more aware of this problem as methods improve. Newer specific drugs have advanced the treatment of a number of the parasitic diseases.

WHAT LEADS the public health nurse to suspect that "human termites" are present in the families she is serving? A careful history often gives many clues—the locality where the family formerly lived, sanitation facilities available, and housekeeping methods of the family. Because tropical disease has been one of the concerns of the public health program in Puerto Rico, many Puerto Ricans have had previous stool examinations and usually know the types of parasites which were found.

The health history may reveal well defined symptoms of diarrhea, constipation, abdominal cramps, bloating, stomach upsets, loss of weight, poor color, and poor appetite. Frequent absences from school, restless sleeping, and nightmares are also clues. Many individuals manifest no symptoms; this is especially true of the large number who are considered carriers. Others with some symptoms are known as subclinical cases. Sometimes stool examination is the only method of removing the uncertainty we have about the individual's health status. The importance of an adequate stool examination is introduced early in our plans with the patient. Our experience has showed clearly the need to begin at this point.

In preparing our patients for this experience, as far as possible we inform them of the procedures and steps of the stool examination, such as the method for collection of warm and cold specimens, the estimated time needed for the examination, what the treatment may involve, and the responsibilities the patient must assume. Travel facilities and directions for reaching the clinic are also given.

Often follow-up visits by the nurse are needed for further explanation of treatment plans and to lend support to the patient. Treatment may extend over a period of months and includes medications, some of which are unpleasant and may cause severe reactions, but the failures in clinic attendance have been minimal. Patients follow through on treatment procedures because they know that there is little danger of reinfection by some of these parasites in this environment; the cycle is broken because of modern sanitation practices and because this climate requires more wearing apparel and additional food which afford further protection from reinfection. Patients successfully treated are conscious of their improvement in health and as a result are interested in promoting their own recovery as well as sharing their knowledge and experiences with others.

The majority of the patients we have referred for stool examinations have been the more recent arrivals in this country because they seem to have the greatest need. Individuals with vitamin deficiencies and intestinal parasites often are underweight and anemic and present a picture of poor health. Good nutrition plays an important role in counteracting the effects of some of the tropical parasites and the diseases they cause. However, the families with whom we are working are in most instances an underprivileged group with marginal incomes whose nutrition is substandard and whose native food habits still tie them to their homeland. Encouraging families to modify their diets to include foods high in iron and calcium and to improve their food habits is a slow process.

*(Continued on page 25)*

# The Teaching Procedures Used in Red Cross Home Nursing

ANN MAGNUSSEN, R.N.

## THE DEMONSTRATION WAY

I'd rather see a lesson
Than hear one any day;
I'd rather you would walk with me
Than merely show the way.

The eye's a better teacher
And more willing than the ear
And counsel is confusing,
But example's always clear.

The best of all the teachers
Are those who live their creeds;
For to see good put in action
Is what everybody needs.

I can soon learn to do it
If you let me see it done,
I can watch your hands in action
But your tongue too fast may run.

And the counsel you are giving
May be very fine and true,
But I'd rather get my lesson
By observing what you do.

AUTHOR UNKNOWN

CIVIL DEFENSE! Civil defense! The words drum insistently on every ear. Civil defense has become a way of life for the American people, we are told. We must learn to live with it and work at it consciously, purposefully, and persistently for many years to come, perhaps.

Why? That's another story.

How? Let's face it. Civil defense is a major concern for all nurses and doctors who share the responsibility for keeping the nation well and strong. The leaders in civil defense planning have said that every person must be trained to protect himself and his family and to help his neighbors in case of illness or emergency. Because the American Red Cross has had long experience in this field and has ready-made machinery in its chapters through which it can reach large numbers of people it has been especially charged with the responsibility of implementing and speeding up this training program. The course devoted to home care of the sick is valuable not only for home use but in shelters or such centers as might be established to meet an emergency situation such as enemy attack.

During World War II Red Cross Nursing Services took a tip from industry which had found a way to save time in training people to do special jobs in the simplest and most efficient manner. The teaching methods used are not new or unique in themselves; they are simply the application of well known and generally accepted educational principles in a manner that has proved highly effective and satisfying to both teacher and student.

The Red Cross home nursing instruction program has been retailored in the interest of speed and accuracy. Known as Home Care of the Sick, the course comprises six foundation lessons, of approximately two hours each, and a seventh lesson which includes essential information for civil defense purposes which will assist the individual to meet emergencies more effectively.

In teaching emphasis is placed upon certain basic principles of teaching and learning, such as:

1. Learning is more apt to result if interest is present and the learning can be related to daily practice.
2. One learns to do by doing, but the doing must be correct.
3. Use promotes the retention of new learning, whereas loss of learning results from disuse.
4. Understanding of the what, how, and whys involved promotes learning.
5. Simple, positive, uncluttered statements lessen confusion and promote understanding on the part of the learner.
6. Guidance in individual performance according to need promotes success and satisfaction and the desire to learn more.

To carry out these principles a few specific provisions are made. Class enrollment is limited to a number which one instructor can supervise—a maximum of fourteen; equipment is available so that all class members may share in classroom practice; much improvised equipment is utilized; instructors receive special preparation before teaching and are given guidance when teaching the first class.

Every lesson is outlined for the convenience of the instructor and to save time. Each is presented methodically through (1) explanation and discussion of the principles involved in a specific procedure (2) demonstration of the procedure by the instructor and (3) practice of the procedure by the student. To follow this routine skillfully, confidently, and with assurance the instructor must be well versed in subject matter and expert in the selection and handling of the teaching aids and equipment utilized. She must also appreciate the differing needs of the individual learners, know how to deal with them, and be able to evaluate constructively the performance of each individual in the class.

## Teaching Procedure

Four major steps are followed in the process of teaching, whether skills are involved or not:

1. *Preparation.* Assembling and arranging equipment and teaching aids; explanation of principles, arousal of interest in the learner.

2. *Presentation.* Demonstration of procedure by the instructor, who at the same time explains *what* is being done, *how* it is being done, and *why* it is being done just that way. Learning is more likely to take place when the learner sees both the process and the end result and understands the reasons for the process.

3. *Performance.* The demonstration is followed immediately by guided practice in the classroom for each student of the major skills involved in the procedure. While one student carries out the activity another tells *what* is being done and *how* and *why* it is being done. This enables the instructor to determine whether the student understands the principles back of the procedure and to anticipate and avoid errors even before they occur. The learner gains self confidence also because she participates in both the *doing* and the *telling*.

4. *Follow-through.* The individual student is given additional help as needed and encouraged to go along "on her own" as soon as she can do so safely. She is also given assignments to practice at home so that she will become more skillful and will acquire confidence in her own ability.

Each procedure to be learned is first broken down into its simplest elements so that it can be taught step by step in logical sequence. Each demonstration is followed by guided student practice.

The success of this teaching plan and the appeal it makes to the trained instructor and the student alike are obviously due largely to the simple positive terminology and the use of *key* words which are easily remembered and which quickly convey an idea. The use of simple improvised equipment stimulates the imagination and the carefully supervised practice gives greater assurance of learning. Even though class groups have widely different educational and experience backgrounds these methods are effective. They have been utilized

successfully for groups with physical handicaps such as blindness or other crippling conditions. With minor adaptations to available facilities and customs they have been welcomed enthusiastically in a number of foreign countries, including Switzerland, France, Italy, Germany, Denmark, Japan, and in some of our insular possessions.

### The Instructor-trainer

Because of the multiplicity of demands upon the time of professional nurses the Red Cross has in the past depended largely on volunteer nurse instructors who were not active in nursing, many of whom had had no preparation for or experience in teaching. In 1946, with the approval of the national Red Cross Nursing Advisory Committee, several experiments were conducted in training nonnurses to teach the Home Care of the Sick course. The results of these experiments were highly gratifying. They proved, without doubt, that carefully selected nonnurses with good educational background, and preferably with some previous experience in teaching, could be trained through these methods to teach home nursing very effectively. The use of these trained nonnurse instructors not only increases the number of volunteer instructors for the Red Cross but makes it possible to upgrade or advance the status of many trained and experienced nurse instructors who have shown special ability in teaching. Since it requires considerable skill and experience to train people to teach, selected nurses who have proved to be competent instructors are encouraged to take the additional training required to qualify them as instructor-trainers. Their time is thus used for a highly technical type of work for which the nonnurse instructor is not eligible.

The Red Cross home nursing training program covers the United States and its insular possessions. It has reached nearly every county and every community at one time or another. It has been taught in the past by thousands of nurses with different types of professional and educational backgrounds and differing standards of technical skill. The end results of such a program varied in quality as did the qualifications of the instructors. To insure a reasonable degree of uni-

### Job Breakdown

**Problem**: Turning a patient in bed with back toward you

**Equipment**: Bed—completely made up for sick person
Student patient—dressed in pajamas

| **Steps**: *Do* words—steps needed to get the job done | *Key* words—how and why<br>The knack or the trick in the procedure |
|---|---|
| 1. Instruct patient | Cooperation and assistance |
| 2. Flex patient's knees | Better leverage for patient to help |
| 3. Free covers | Easy access to patient—patient covered and comfortable |
| 4. Arrange for signal | Nurse and patient working together—avoids confusion and waste of energy and motion |
| 5. Place hands | One under shoulders, fingers cradling, one under hips, fingers extended to far side, cradling hips for secure grasp, ease in turning, and for safety to patient |
| 6. Adjust own posture | One foot forward, knees flexed, bending at hips—back straight—to save energy and avoid strain |
| 7. Turn patient | Pulling back and at the same time turning patient over on side, maintaining hold until patient is turned |
| 8. Adjust patient's posture | Head, shoulders, hips, knees, and ankles adjusted and supported to avoid strain and assure comfort. |

formity in the content of the course in Home Care of the Sick and an acceptable standard of teaching performance it became necessary to provide a teaching guide and to develop a training course for instructors. The present instructor training course, after several years of experimentation and adaptation, seems to meet the need and at the same time to have broadened the concept of teaching among nurses.

The use of the instructor's guide is essential to safeguard course content, sequence, timing, and methods of teaching. However, instructors well trained and experienced in these methods of teaching are privileged to make necessary adaptations for individual students or for unusual community or living conditions. They are encouraged to enrich the course as seems necessary or as time permits.

The Red Cross recognizes that in the art of teaching no one method is in itself sufficient. It remains for the skillful teacher to make sound application of the basic principles fundamental to learning. One of the problems facing the nursing profession in this time of emergency is how to increase the number of trained and skillful instructors who can give this vital knowledge of home nursing to large numbers of people.

*Miss Magnussen is national director, Nursing Services, American National Red Cross, Washington, D. C.*

# Public Health Nurses Are Interested in the Chronically Ill

E. LUCILLE WALL, R.N.

WE HAVE ATTEMPTED to stimulate the interest of groups of public health nurses in Indiana in gerontology and chronic diseases. In order that you may understand the "we" I would like to tell you how the public health nursing consultants function in our state. The State Board of Health is decentralized into five branch office areas in order that services may be more accessible to local communities. The consultant nurses, who provide generalized service, work from the branch offices and the specialized consultant nurses have their headquarters in the Division of Public Health Nursing in the central office of the State Board of Health. The two groups of consultant nurses work closely together. The channel for getting programs in special fields to local nursing services is through the generalized nursing consultants.

Thus when it became my responsibility as consultant nurse in the Division of Gerontology and Chronic Diseases to develop the nursing aspects of the program of the division my first approach was to work directly with the generalized consultants. These consultants wanted suggestions for stimulating activities of the local nurses in the area of chronic illness.

We agreed that before we made any plans we needed information about the following: (1) the attitude of the nurse toward gerontology and chronic disease (2) the knowledge the nurse already has in this area (3) the services that are now being given to the aging and to those with longterm illnesses.

When we learned that the nurses in one branch area had chosen the topic of chronic illness for their nursing conferences for the

coming year we decided to work with that group and see if a pattern could be developed that might be applied to other branches. A local committee was formed, composed of five staff nurses representing the various types of public health nursing services in the area, the two generalized nurses and one specialized consultant nurse, and the director of the Division of Gerontology and Chronic Diseases. For some time this committee considered carrying out a survey to find out the extent and types of chronic illness in the community. The nurses could collect a good deal of necessary information by keeping a running report of the chronically ill whom they were serving and also about whom they learned through their contacts with families, physicians, and other sources.

But the committee thought the collection of such data might be disturbing to the staff nurses because it was impossible for them to increase their current caseloads. So the idea of the survey was dropped and the decision made to give the nurses help in meeting the needs of the patients with longterm illnesses whom they already were carrying. The nurses needed help in evaluating what they were doing for these patients and in developing ability to give a more complete family service in situations where the chronically ill were involved. The committee recommended that:

1. A roster should be compiled of the names of the chronically ill on the active caseload.
2. A list of chronic illnesses should be prepared as a guide to the nurses.
3. A guide for the analysis of the conditions related to the chronically ill and their families should be set up so that nurses might use this in analyzing the service they give.

Forms for these lists and guides were prepared and are being distributed to the staff. The nurses are eager to improve their care of the patient with longterm illness and accept the forms as a technic which will help them.

Three other branch offices have expressed interest in concentrating their nursing conferences on the aging and chronically ill.

We know we cannot carry out the same type of programs for nurses in all our branch areas and that it is well to consider the wishes and needs of groups as expressed by themselves. We know that when educational programs are practical and meaningful to the staff nurses they are interested and enthusiastic participants. In Indiana a large number of our public health nurses are interested in the problems of the aged and chronically ill and we believe their service to patients in these categories will be improved because of this interest.

*Miss Wall is consultant in gerontology and chronic diseases, Indiana State Board of Health.*

## Parasite Family

*(Continued from page 20)*

We feel we are one step forward in our nutrition teaching if the patient can first be rid of the parasites and thus gain full benefit from the food he eats.

In helping families we have recognized the need for eradication of intestinal parasites when indicated as a preliminary step to better health. The work of the public health nurse and that of other individuals in the health and social welfare fields can make an important contribution to this phase of medicine and lead to stronger health defenses in a cosmopolitan society.

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# Public Health in India

MADAME VIJAYA LAKSHMI PANDIT

ANY WOMAN IN public life must inevitably interest herself in the nursing profession because of its importance to matters which concern the nation as a whole. That interest is even greater for me because for several years I had the privilege of holding the portfolio of public health in my state government and thus came into direct contact with a number of problems which adversely affected our national existence. Since poverty and ignorance are two of the basic factors underlying the health problems of a country we have in India an almost superhuman task in trying to build up the nation's health. Our low economic development does not allow for the creation of an environment conducive to healthy living, nor is adequate health protection possible for the people. Lack of sufficient general education and health education is a powerful contributory factor in keeping the welfare of the country at the present low level.

This is indeed a grim picture but one that the government of India is working hard to change. I know you will be interested in having a glimpse into the pattern of life and social responsibility in the old India as well as in learning about the steps being taken in the new India to raise her health standards.

Social welfare in India was not until recently a direct concern of the state. In the old days the care of the sick was the responsibility of the family and the community. Voluntary community effort was often supplemented by the efforts of social workers who were inspired by humanistic and religious ideals and were organized into special brotherhoods. Care of the poor and sick was to them something like the practice of religion itself. In serving man they served God.

Social conscience and community life were greatly influenced by two faiths in India, Buddhism and Vaishnavism, which glorified any voluntary effort for the relief of human suffering and pain, thus making of service a mission. This tradition, fortunately, still exists, though in a modified form. Today we see it in the Ramakrishna mission hospitals spread all over India, doing work which deserves the highest praise.

As the old patterns of village and community life disintegrated under the combined pressures of the industrial age and foreign rule, and the economic situation worsened, the problem of public health became particularly acute. Voluntary effort on an unorganized basis could no longer cope with the situation, and the help provided by a foreign government was unimaginative and grossly inadequate and confined to the larger cities. The rural areas were neglected, even the village dispensaries being few and far between.

In 1937, when I took charge as minister of health in my home state of Uttar Pradesh in North India, the immediate task before my department was how to provide elementary medical aid for the villager; secondly, better hospitals; and last, but not least, more nurses. Lack of funds was only one of the difficulties that faced us. The Medical and Public Health Departments were handicapped on account of the very complicated organization of the services, and the task of administration in these departments and the effecting of improvements in keeping with

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*Madame Pandit is ambassador from India to the United States. She presented this paper at the luncheon meeting of the Public Health Section of the New York State Nurses Association in October 1951 in New York.*

modern requirements became a difficult problem. Piecemeal improvements could not give the relief the state demanded, and a complete overhaul of the Medical and Public Health Departments, so sorely needed, could not be carried out unless certain legislative measures were enacted. The processes of democracy are slow and before laws can be passed in a country like India it is necessary to win the confidence of the people and insure their cooperation.

AS AN IMMEDIATE gesture to give confidence to those who were suffering from lack of medical facilities we planned a program so that no villager need walk more than a distance of three miles to get to a dispensary where there would also be facilities for a few beds to be used for emergencies. My home state may be compared in area to your own state of Indiana. No program can be effective overnight, and we had to content ourselves with a ten-year plan, in which time we hoped to cover the whole area with a network of dispensaries, to be further aided by ambulatory clinics which would visit each village at least once a week. In addition to rendering elementary help, such as the performance of minor operations, for which they were equipped, they would take the more serious cases to the nearest hospital.

Since 1937 this plan and others have been put into action. But though the picture of the village is better a task of gigantic proportions still remains to be done. It was not easy to impress upon our people the importance of public health and the value of preventive medicine. The Public Health Department received no popular support except in times of epidemic when it was expected to work miracles. Conditions in Uttar Pradesh were merely a reflection of conditions in the country as a whole, where maternal mortality and diseases such as malaria, tuberculosis, and cholera claimed thousands of victims annually. Realizing the need for an overall survey the central government appointed a Health Survey and Development Committee. The health program of today is based on the recommendations of this committee, which also laid the basis of a modern nursing service.

Prior to independence, however, the facilities for training remained patently inadequate. I quote figures from the report of 1943.

There were only 7,000 trained nurses in India at that time. This works out roughly to one nurse for 43,000 persons. Our goal was to raise this, as in the case of Britain—at that time—to one nurse for 300 persons. This meant a total of 74,000 nurses. Our midwives numbered 5,000. We wanted 100,000 more. We had 780 health visitors, although 74,000 were required—a sad picture.

The reasons for this state of affairs were not far to seek. The nursing profession in India did not attract the right type of candidates. Lack of status, low salaries, and poor housing were among some of the causes which deterred many intelligent young women from joining its ranks. A more basic cause was the fact that midwifery had been confined to the lowest castes in the past and was not considered a proper profession for girls of good family. The midwife was untrained and was a danger to society. But custom dies hard and it has not been easy to change the existing pattern. Years of patient effort have finally yielded fruit in the shape of a more or less universal acceptance of more modern methods. Owing to the great difficulty of getting personnel many states have attempted to train these midwives, and the results have been satisfactory. They occupy today a position not dissimilar to your own "granny midwives" in the South.

The government of free India took a serious view of the situation, and training of nurses was given high priority in the program of national regeneration. It was realized that without a considerable increase in their number, and without a coordinated policy for their instruction, professional status, and other amenities, it was impossible to proceed with the development of hospital and other institutional facilities and with the organization of the public health nursing service for curative and preventive work in the homes.

The first students to complete the four-year degree course were graduated from the Delhi University in 1950. The Indian Nursing Council was established in 1949 with the following primary objectives:

1. Coordinating the activities of the various state councils
2. Developing standards for basic and advanced training of nurses
3. Regulating hours of work, minimum wages, housing, old age benefits, and other professional amenities
4. Turning out an increasing number of trained nurses in order to make the expansion of the related health services possible.

Under the able guidance of Rajkumari Amrit Kaur, minister of health in the Central Government, great progress is being made. Inaugurating the Indian Nursing Council, she said, "It is not only personnel skilled in the act that are required but the strength of spirit within that will radiate sympathy, kindness, human understanding, and the patience that is necessary if the profession is to rise to the high standard expected of it. Not for nothing is the great woman who founded this profession called the Lady of the Lamp. May the torch she lit never be dimmed. I have always felt that women are special custodians of correct behavior and instinct, with the desire to alleviate pain and suffering. I therefore expect them to make their full contribution to the raising of ethical standards in all hospitals and nursing homes."

IN SPITE of considerable achievement it should be recognized that the development of the nursing services cannot be isolated from the general rhythm of development of health measures for the country as a whole. The first five-year plan of our National Planning Commission lays considerable emphasis on this coordinated program.

Political thinking all the world over has in recent times tended to look upon the state more and more as a welfare institution. The outlook of the Indian Planning Commission has been no exception. It has visualized increasing responsibility on the part of the state for planning public health services and their execution. Economic development largely depends on the physical health of the people. The incidence of sickness and disability, the death rate and the expectation of life at various ages, determine the quantitative and qualitative use that can be made of available manpower. Health planning cannot, therefore, be treated as an isolated matter but should be treated as an interrelated activity in any comprehensive program of national development.

The limitation of funds available for expenditure on health makes it imperative that any health program for the next five years must be based on a careful consideration of priorities and that the approach to various problems of health must be in keeping with the basic economic conditions in the country. The Planning Commission gave very high priority, for instance, to measures designed to reduce the high incidence of sickness among those engaged in productive occupations. It was recommended that during the next five years additional resources should be concentrated on preventive work rather than curative facilities. Also, rural areas, especially those singled out for intensive development, are to receive much greater attention. Malaria, tuberculosis, maternal and child welfare, and occupational diseases also have high priorities. In regard to the training of nurses and midwives the Planning Commission naturally recommended rapid expansion of the existing facilities. The commission also stressed the need for training a type of rural health personnel which would be capable of performing under special medical supervision such preventive duties as inoculation, vaccination, identification of minor ailments, distribution of simple medicine, et cetera.

I would like to acknowledge the debt we owe to the United States for the selfless work done by its medical missions in India. All over India American men and women have worked in hospitals and dispensaries, in towns, and in the remote rural areas, to give life and health to our men and women and children. The love and sympathy they have put into their work have created the only kind of relationship that has a lasting value. We honor them, and I look forward with confidence to the day when the people of my country will have the health and security which are their birthright. America and India both have a role to play in the shape of things to come. I believe it will be a role of mutual benefit and honor.

# A Challenge to Health Councils

SAMUEL PESKIN

THE NATIONAL Health Council's current study reveals that by and large all metropolitan health councils are pretty much alike in their structure, their membership, their financing, and their methods of operation. How effectively they do their job within the limitations under which they work is basically determined by three things: (1) the ability and devotion of their staffs (2) the interest, social vision, and leadership qualities of their officers and board members and (3) the degree to which the council members understand and accept the principle of cooperative planning and joint action.

That there is need for improvement all health councils agree. Most metropolitan health councils are seriously understaffed. All of the health interests that could and should contribute to the support of a council and participate in its activities very often do not. Although the majority of health councils have the nominal membership of independently financed health agencies they do not get full and wholehearted participation from them. Some important voluntary health agencies do not have formal membership in councils. In many instances it is because the councils are so closely identified with the community chest and chest-supported agencies that agencies outside the chest are reluctant to participate fully and wholeheartedly, even if they are free to do so. Many such councils, because of their lack of autonomy in relation to their chests and welfare councils, are unable to operate with the degree of freedom they feel they need to function most effectively.

All of these problems are admittedly serious. They drastically limit the usefulness and effectiveness of metropolitan health councils. But boards and staffs are becoming increasingly aware of them and are attempting to correct them.

However, there is another, even more serious problem—a problem the true importance of which is often not fully realized. It concerns lay membership. In some councils the majority of members are professional workers in the health and welfare field. Many other councils have a large proportion of lay members. But most lay members, whether their proportion is small or large, are officers or board members of health and welfare agencies. Lay members representing other segments of the community—those who represent civic and social groups and those who are not identified with any organized group—are limited to a specified minority by the constitutions and bylaws of all metropolitan health councils.

Let us examine the purposes for which lay membership has been and is still being sought. As councils see it, such membership is needed for the citizen understanding and support it will bring as well as for guidance. Lay participation is looked upon as a method by which leading laymen can acquire a knowledge and understanding of health and welfare needs and programs and so be more willing to serve and support them.

The National Health Council's recent study and studies made by Community Chests and Councils[1] reveal various technics that are being employed to develop broader lay membership and participation—to bring in representatives of civic, labor, industrial, religious, fraternal, and other citizen organizations. One is the provision for representation of these groups on the delegate body of the council. However, since delegate bodies of most councils meet only two or three times a year these representatives have little oppor-

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tunity to become involved in the day-to-day functions of the council. Another method is to give citizen organizations with declared health or welfare interests membership on council sections or divisions. Some councils bring in representatives of such organizations to serve on special project committees. In some communities there are separate councils of civic organizations to which the health and welfare councils turn for assistance and support.

This is all necessary and highly worth while. But it hardly goes far enough. The responsibility and the direction remain in the hands of a comparatively few influential laymen and professionals.

The number and variety of organized groups in America, and the sheer bulk of their membership, lead to the impression that citizen participation in community activities is practically universal. I quote from Fortune magazine's *U. S. A.—The Permanent Revolution.* It has been estimated that there are more than "200,000 organizations, associations, clubs, societies, lodges, and fraternities in the United States, along with innumerable social groups and ad hoc committees formed for specific causes." In Cedar Rapids, for example, it was found that there were "372 organizations, counting labor unions and religious groups, but not counting hundreds of social and specialty clubs such as the Ladies Literary Club, the Gladiolus Club, the Merimyx Dancing Club, the Bird and Natural Science Club, and the Society for the Preservation and Encouragement of Barber Shop Quartet Singing.

"The ordinary citizen's off-duty activities may include working for the removal of the billboard at the corner of Elm and Sixth, raising money for a new gym at the high school, campaigning for a city-manager plan, serving on the board of the state health council, fulfilling duties as a member of the Rotary and the Chamber of Commerce, the Symphony Society, and the hospital board, and giving time and money to such organizations as World Federalists, the Committee on the Present Danger, the Independent Committee to elect so-and-so to the Senate. Except for a few intellectuals who don't believe in 'joining,' and the poor who can't afford to, practically all adult Americans belong to some club or other, and most of them take part in some joint effort to do good."[2]

A MORE CAREFUL analysis, however, shows a rather different picture. Hillman cites a recent study by Mirra Komarovsky of organized group affiliations of 2,223 adults living in New York City which found that "the majority belong to no organizations . . . 60 percent of working class and 53 percent of white collar men in this study did not have a single organized group affiliation. Eighty-eight percent of labor and 63 percent of white collar women were without any affiliations. Indeed, in all occupational classes, male or female, earning under $3,000 and other than professional—that is, in the bulk of the city's population—the unaffiliated persons constituted a majority. Conversely, it is only when we reach the business classes earning $3,000 and the professional classes that the majority is found to be organized. This study included recreational groups as well as civic, economic, and others with community interests and activities."[3]

And even when this limited segment is drawn into our councils we see the relationship as a passive one. As Violet Sieder of Community Chests and Councils points out, lay groups are used by councils as a channel through which (1) to interpret needs and services to the community and to reflect its needs, opinions, and readiness to accept plans and proposals (2) "to integrate the *direct* health and welfare programs [conducted] by many of these groups into the total pattern of community services and (3) to harness the tremendous potential power of the membership of these organizations for volunteer work on boards and committees, on special projects, as campaign assistants, and as voters, taxpayers, and contributors."[4]

As long as our agencies and councils are looking to lay citizens merely for understanding, financial support, and help with the programs which are planned and conducted mainly by professional staff, this approach would seem to serve our purpose. But what is the basic nature of our programs? What

have we been trying to do? And where has it got us?

Our programs, by and large, are centered on providing treatment for a variety of specific illnesses and handicaps, and, if we have any personnel and funds to spare, on working to prevent them. We have achieved considerable success. Tuberculosis, once our leading cause of death, has been reduced to seventh place. Infant mortality has never been lower. Our communities have never been so free from infectious diseases. Even many sufferers from such chronic ailments as diabetes and heart disease can now with proper treatment and supervision live happy and productive lives. We can now realistically foresee the cure or control of the major killing diseases of our time. And never has the country been so fully provided with hospitals, clinics, sanatoriums, convalescent homes, and other special services to care for the ill and the handicapped; never has it had so many facilities, such as public health services, disease detection programs and health education, for the control and prevention of illness. Yet in spite of this tremendous expansion the needs for these and other services and facilities are increasing rather than diminishing. The success of modern curative medicine and surgery and preventive medicine has been so spectacular that we have thought they could finally solve the problems of human pains and ills. But illness changes from person to person, from community to community, and from generation to generation. It invents new symptoms, takes on fresh masquerades. And so we find that while many diseases are being cured, controlled, and prevented, others—particularly the "multiple-stress" diseases—are increasing. It seems that in adding years to our lifespan we are merely adding years of ill health.

We must, therefore, conclude that these measures are not enough, that they are insufficient to remove disease. We must work more assiduously and more effectively for the development of health in its true sense, that is, for positive health.

Today we see clearly we are faced with a new goal—that each one must assume responsibility for himself. It is not enough for health workers to make knowledge available. The individual must decide for himself to accept such knowledge and make it part of his way of life. Such a goal carries its own challenge to health programs. Only when the bulk of our citizens participate in health, welfare, social, and political activities will we achieve a working democracy and advance the cause of human welfare in our communities, our nation, and the world.

ATTEMPTS are being made in a number of cities to devise technics that will enlarge the base of citizen involvement. But it is in our rural communities, particularly in the last few years, that the greatest progress has been made.

For example, the Ohio Farm Bureau Federation has fostered the organization of "approximately 1,500 advisory councils, each consisting of from ten to twelve farm families, which meet once a month at one another's homes. These are small discussion groups where current farm, home, and community problems and needs are considered. Professional guidance and leadership are made available to them through the state and county offices. When important issues of concern to the membership at large are up for consideration by the Federation Board these advisory councils are asked to discuss these issues and report their conclusions to the board. In this way a large segment of the membership feels it has had a voice in developing the policies and plans of the organization. The Ohio Farm Bureau Federation has demonstrated that this technic actually works and that it has possibilities for wider use."[5]

A similar development is being fostered by agricultural extension and home demonstration agents in a number of states and is achieving remarkable results. For example, in the state of New York more than a quarter of a million citizens are working on committees for the improvement of the health and safety of their homes and communities.

Conditions of life in our urban communities have tended to decrease the feeling of individual responsibility. The growth of our cities, the influx of people with different ideologies which makes communication among our

citizens more difficult, the rapid development of technology which leads us to hope for gadgets that can solve our difficulties—these and other developments have tended to divorce individuals from a sense of responsibility in the various activities with which they should be concerned. As one social planning council has put it, we have concentrated on providing substitutes rather than supplements for personal responsibility and personal effort.[6] The problem is to find ways of restoring this sense of responsibility in our metropolitan centers.

Ralph B. Spence of Columbia University Institute of Adult Education suggests that "psychologically, the answer would seem to lie in getting a close relationship between the activities of our urban dwellers and the consequences. . . . Paper membership and financial contributions alone will always be ineffective."[7] This process in our urban communities is being implemented through local community or neighborhood councils.

In New York City neighborhood organization for health began as early as 1936. Neighborhood health committees were established originally to help interpret the work of the official district health center, operated by the Health Department, to the local community and thus act as a liaison between the Department of Health and the people in the district. Eleven years later a survey was made and as a result the Health Council of Greater New York changed its program of community organization for health. Since 1948 about 1500 men and women, representing all types of groups and associations, have participated in the eleven community health councils, which are carrying on a great variety of health programs in the city.

Neighborhood councils give promise of attaining the "democracy in action" which must be achieved if our urban communities are to become "good" communities. Here is the definition of the "good" community which Jean and Jess Ogden of the University of Virginia have evolved out of their long and rich experience in helping communities to help themselves:

"That community is a good one that bases its stability on the fact of change rather than on the hope of keeping things as they are, for . . . we are living in a world of change . . . [and] . . . must find our balance in motion. . . . That community is good which . . . implements [the] philosophy of . . . acceptance of change . . . by awakening in each citizen an eagerness for change and by equipping him to guide it.

"That community is good which strives to make each individual master of his own circumstances and environment rather than to train him to fit into an established pattern. . . . That community is good which recognizes that a voluntary teamwork of many interests and of many skills is vastly superior to subordinating those skills and interests to already established leadership, no matter how farseeing, efficient, and benevolent. . . . That community is good which is more anxious to discover and encourage new leadership than it is to support—or even to overthrow—the old, [for] in a democracy everyone is a leader. . . . That community is good which makes possible a more abundant life in its broadest interpretation . . . To the extent that it limits [the] potentialities of any of its citizens, it is not a good community."[9]

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Presented at the annual meeting of the Health Council of Metropolitan Detroit, June 1951.

# Staff Evaluation

ELISABETH H. BOEKER, R.N., and CELIA L. CARPENTER

O wad some Pow'r the giftee gie us
To see oursels as ithers see us!
It wad frae monie a blunder free us,
And foolish notion.

BURNS

THERE WAS NOTHING new in the stimuli that started the staff of the Division of Public Health Nursing in Maine on the trail of that elusive ideal—performance evaluations that are objective, consistent, and accurate. The staff nurses didn't like the rating system; the supervisors didn't like the tools they were trying to use; nobody liked the results. They said so both in private conversations and in staff conferences.

Naturally criticism was aimed at the forms being used, so we collected forms from other states and agencies. The more forms we looked at the more we wondered whether any form would accomplish our purpose. Perhaps it was all a problem of educating supervisors to use a rating form. But the general vague qualities listed on our form were of so little help that we didn't know how to begin, and the idea of adopting another ready-made form or trying to adapt one to our use left us cold.

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We knew the task of developing a new rating system was an arduous one, and we hesitated. But in the end it seemed the only course worth following and, almost without our volition, we found ourselves in the planning stage. We discussed the project with members of the United States Public Health Service and with others interested in the subject. Attention was focused on evaluation problems in discussions at local and state conferences.

To develop a new rating system we agreed to start by selecting our own job elements and setting up standards of performance for them. We decided to launch our project at the two-day annual spring meeting of public health nurses in Augusta. The dominant note was to be "full staff participation," and we planned a workshop setting. We rounded up advisers from both the nursing and personnel fields and invited them to serve as resource people.

A short time earlier all nurses had prepared individual job descriptions. In preparation for the workshop we collected these and the statements of the official position descriptions approved by the State Personnel Board. When we studied these we found that the duties fell into four groups which for convenience were labeled Program Organization, Family Service, Clinics and Conferences, and Community Services. Under Organization

were such statements as "participates in staff education program," "keeps supervisor informed," and "maintains orderly office." This section proved to be something of a catchall for those things which clearly did not belong under the other three self-explanatory headings.

Copies of this material and letters describing our plans, purposes, and the role each nurse was to play in her work group were sent in advance to the participants. Despite the general dissatisfaction with the current rating system we were far from sure that the proposed agenda would be hailed with delight, but we were off on our venture to have a staff-built staff evaluation tool.

The workshop was opened with a pep talk designed to arouse the enthusiasm we were afraid was lacking. "Evaluation of performance is a process which goes on all the time, whether we like it or not. It is an essential of supervision. If we had no supervisors we still would be evaluated by those we serve and those who observe us in action, and if we were free from those evaluators we could not avoid evaluating ourselves. How well this process is being done is a question. Our relationship to our supervisor makes her evaluation important to us. We may flinch from the process, but we want to know what she thinks of our performance. We want her to think straight about our strengths and weaknesses and to offer help where we need help. We want her to recognize the difficulties we face and be realistic in her appraisal. This is a big order and supervisors need a helpful guide to perform such a difficult and delicate task well. Perhaps in the workshop we can make a start in the development of such a guide."

Four groups were set up, three composed of staff nurses only, representing all six districts. The fourth group was composed of supervisors and one staff nurse from each of the districts. We thought this a unique feature of our project. In their group discussions we wanted the staff nurses to be free from supervisory influence. We did not want the supervisors free from staff nurse influence.

According to plan the first afternoon was devoted to a discussion of how to meet the need for a better rating system, and to practice in breaking down the statements in the job description into ratable duties; the second morning, to practice in writing descriptions of performance at various qualitative steps; the second afternoon, to summarizing results and determining whether further work would be worth while and, if so, how it should be carried on.

Each group had a leader and recorder and resource people were available on call. If the report so far suggests that the nurses were being regimented and directed in their approach you should have seen the freedom and initiative demonstrated in the groups! One group spent considerable time in discussing what was wrong in the old system and what was wanted in a new one. One group went to work almost at once on the breakdown of the section of the duties allotted to it and covered the waterfront. One group had some discussion and then did a meticulous breakdown of the duties listed in the section assigned to it.

When it came to practice in writing qualitative standards there was the same degree of diversity of approach. Some attempted only a "satisfactory" description, some wrote three quality levels, some covered many elements hastily, and some attempted very few and worked diligently in refining these. Nurses with a gift for words made their debut. Nurses with a gift for analysis and logical organization brought order into the situation, which at times was a bit chaotic. Everyone participated freely and fully. The resource people went at a dogtrot in attempting to be on the first, second, or third floor as needed.

Between sessions recorders and leaders met and discussed methods and progress, and the nurses continued discussions over lunch or in conversational groups. When the workshop convened as a group on the second afternoon summaries of its activities were presented. This was followed by general discussion. Certainly there was no question about the interest of the group. Each one had had the opportunity to express her ideas and share her opinions. Everyone knew, as she had not at the beginning, that the task had only been started. There was no finished product; an approach had been made and an increasing understanding of the job to be done had been achieved.

Yet there was unanimous agreement that the work should go on. Plans were made to continue work on evaluation at district staff meetings throughout the year. Each section of the evaluation form was to be divided into duties which could and should be considered separately in arriving at a fair evaluation of performance.

After the districts completed their work on job elements a central committee of staff and supervisory nurses reviewed and refined the statements. This turned out to be another two-day task. The central committee was assisted by the original planning group. They struggled to get rid of the overlapping which naturally resulted from the division of the work. Obviously a sharp line cannot be drawn between clinic service and family services; other breakdowns showed other close interrelationships in the nurses' activities. However, the material finally emerged as a logically arranged list of duties. Anyway, it looked good to us.

The heading, Organization, was changed to Administrative Responsibilities. Some of the duties were transferred from one category to another, which seemed more appropriate. It was recognized that all service is service to the community. Yet we felt that family service and clinic and conference service responsibilities should maintain separateness for the sake of emphasis. The fourth category became Other Community Responsibilities.

With forty-eight persons participating in a task for which they had only two days guidance, changes in organization and language were to be expected. Does this mean—as some skeptics would undoubtedly say—just as I thought, a fine idea, having the nurses develop their own standards, but in the end it will be like all other standards, the work of a committee? Well, the central coordinating committee included staff nurses, and if you who are skeptical could have listened in you would have heard something like this, "That completes the section on clinics and conferences. Let's get on to the next topic." Or, "Wait a minute, there's something lacking in the responsibility of the nurse in a clinic. I don't know just what it is, but there's something missing." Then the struggle began and we started over again once more.

If we have learned anything about the public health nurses in Maine we know that the committee report will not be accepted without careful checking and analysis. Any change which has in fact, though inadvertently, done violence to the kind of breakdown that lends itself to appropriate emphasis on the elements of the nursing duties as seen from the viewpoint of the staff nurses will jolly well get changed right back again. This does not mean that the material may degenerate into a hodgepodge of unrelated statements in order to attempt the impossible, satisfying each staff member's whims. It does mean that each phase of performance will receive the degree of emphasis the nurses as a group believe it should have, and each will be placed in the setting which the group believes will facilitate the supervisor's appraisal of it.

And when all that is settled we will go on with the next steps. At our next annual meeting we may be ready to consider how to set up the material we have prepared into an evaluation form and how to assign weights to special job elements. So we are really reporting on a project well under way but far from finished. Perhaps we have missed a few points that should have been included. We recognize that the task of setting standards of performance is not wholly the prerogative of the staff nurses. Supervisors have a right to their opinions as to how the job should be done. In general it is the quality of such opinions which made them supervisors. The agency has policies which must be recognized by all staff members. These two things must be and will be taken into consideration, but within these limits the staff nurse will have an important part in setting up the standards for her job performance.

Most important of all, we want to emphasize that the value of this project does not depend on the end product or even on its completion. Every hour spent on the task has given value in return. The nurses have gained and developed new skills; they have gained new insight into their responsibilities. The development of qualitative levels of per-

*(Continued on page 51)*

# International Health

## KOREAN REFUGEES AIDED

A worldwide concern for the plight of the millions of civilian victims of the Korean conflict is being reflected in the civilian relief program of the United Nations. The outbreak of hostilities in Korea caused the mass evacuation of men, women, and children from both North and South Korea toward the southern tip of the peninsula and created an urgent problem of relief and medical care. At times there have been as many as 8,000,000 refugees. The secretary general of the UN called on member governments, specialized agencies of the UN—such as WHO, the Food and Agriculture Organization, the International Refugee Organization—and nongovernmental organizations to contribute to the civilian aid program.

The United Nations Command has requested the services of doctors, sanitary engineers, and public welfare officers to aid in the health and welfare programs in Korea. Thirty-seven specialists now in Korea are distributing supplies and immunizing vast numbers of civilians against smallpox, cholera, typhoid, and typhus.

The United States has provided approximately $85,000,000 worth of goods and services, and other governments have provided a total of $21,000,000. Nongovernmental organizations and the UN specialized agencies have also made numerous offers of assistance.

Anticipating a longrange rehabilitation and reconstruction program in Korea the General Assembly created the United Nations Korean Reconstruction Agency (UNKRA). On April 1 UNKRA began to function, taking over some operational and planning phases of the program.

### RED CROSS REPORT FROM KOREA

The Korean Red Cross, reorganized following World War II with the assistance of the American Red Cross, is helping to provide medical care and relief to the civilian population. Operating hospitals, clinics, and mobile medical teams, the Korean Red Cross offers the only medical facilities available in some areas. It is carrying on this program under great difficulties since all its installations caught in the territory occupied by the North Koreans were looted and destroyed. Fifteen Red Cross international personnel are now serving on the UN welfare teams in action in Korea as advisers to the Korean government.

Military and indigenous agencies and international welfare personnel put forth a spontaneous effort last fall on behalf of the estimated 3,000 orphans and displaced children in Seoul, providing shelter, food, clothing, and medical supplies.

Total contributions of Red Cross societies, excluding those of the American Red Cross, amount to more than $700,000. The American and Junior Red Cross contributed $400,000 to the Korean refugee program.

## UNIFIED SANITARY REGULATIONS

In May the Fourth World Health Assembly adopted the International Sanitary Regulations. This event, which was welcomed as "the greatest step forward ever recorded in this oldest field of international public health," consolidated and replaced all sixteen international sanitary conventions now in force. The regulations will take effect automatically on October 1, 1952, without the need for ratification by individual member states of WHO.

These rules are by no means perfect, but they are a considerable improvement over the existing conventions, which are neither uniform nor altogether rational. The new code was drafted by groups of specialists on epi-

demiology in the light of modern concepts of communicable diseases and their control. Some of the features which make this new code better adapted to modern conditions are the following: requirements for smallpox vaccination certificates have been made simpler, in that certificates may be delivered immediately after vaccination without waiting for a later reexamination; the regulations provide for the establishment of "areas of direct transit" in airports adequately protected against local infections so that long-distance travelers will be able to pass through these zones without being subjected to quarantine measures; the need for measures to prevent the export of infection from one country to others is stressed; for example, travelers leaving a territory infected with yellow fever must be vaccinated before their departure.

In this dynamic new code machinery is provided for continuous review and amendment wherever necessary as well as for settlement of disputes arising from the application of its provisions. This will be done through the WHO Expert Committee on International Epidemiology and Quarantine. All measures prescribed in the International Sanitary Regulations are conceived as *maximum* precautions which should be relaxed as more and more knowledge is acquired on control of diseases. The ultimate goal is "simple, free, and safe travel."

Countries are requested to take additional steps in order to protect their own populations from within. Recommended measures to improve general sanitary conditions include the elimination of rodents, mosquitoes, and other carriers of human diseases, particularly in and around sea- and airports.

WHO *Newsletter*, May-June-July 1951.

### WORLD POPULATION

Since 1900 world population has increased by more than 800,000,000, half of this total being contributed by Asiatic countries. All of the fifty-two countries included in the study showed a general increase in population, with the sole exception of the Republic of Ireland. The largest proportional increase was in Argentina, which has had a population increase of 251 percent since 1900. The American continent had the greatest relative increase, and Europe had the slowest. Non-European countries show accelerated rates in the twentieth century, compared with European countries which experienced their most rapid population growth earlier.

WHO *Newsletter*, August-September 1951.

## American Journal of Nursing for January

Pulmonary Resection
1. History and Modern Technics . . . Walter F. Bugden, M.D.
2. Nursing Care . . . Ellinor Bickford, R.N., and Esther Budd, R.N.

Rooming-in in Pediatrics . . . Helen Dumack

Coordinating Nurse Power for Civil Defense . . . Harold L. Althouse, R.N.

The Pneumonias . . . Robert Austrian, M.D.

Home Adjustment of Rooming-in and Non-Rooming-in Mothers . . . Nilda Shea, R.N., Ethelyn H. Klatskin, Ph.D., and Edith B. Jackson, M.D.

Frostbite . . . Agnes Spock Ward, R.N.

Your Foreman Will Work with You . . . Eve Morkill, R.N.

Before the Coordinator Comes . . . Sister M. Thomas, R.N., and Anna Hassels, R.N.

# *Abstracts . . .*

## COSTS OF HOSPITALIZED ACUTE ILLNESS

This study of costs of hospitalized acute illness was sponsored by the Medical Society of the District of Columbia for the purpose of obtaining current information on "(a) the costs of hospitalized illness among nonindigent persons and the relation of costs to family income (b) the division of costs among hospital, physician, and other services and (c) the degree to which prepayment plans are helping their members to meet the costs of illness involving hospitalization." Based on data gathered from 1796 private patients in hospitals in the District of Columbia during November and December 1949 and January 1950, this report gives the total medical-hospital costs and the actual cost to the patient. By definition the episode of illness was limited to one month prior to and one month after hospitalization for medical and surgical cases and included the entire antepartal period for obstetrical cases.

It is interesting to note the distribution of patients according to age and sex. Up to fourteen years of age male patients far outnumbered female patients. After fourteen female patients outnumbered the males three to one, and even when obstetrical cases were excluded there were almost twice as many females as males.

The average total hospital-medical bill was found to be $285. Separated into specific categories of hospitalized illness, the total costs were as follows: for surgical cases, $304, for medical cases, $213, for obstetrical cases, $304. The major part of the expense was hospital bills and physicians' fees. The total average sum, $285, included $131 for hospital charges, $109 for physicians' charges, $15 for anesthesia, $6 for radiology, $10 for special nursing, and $14 for other costs such as laboratory work, ambulance, electrocardiography, and physical therapy.

Length of stay in the hospital averaged 7.4 days. Medical patients stayed the longest time, 8.8 days, obstetrical patients the shortest, 6.4 days, and surgical patients averaged 7.3 days.

About 70 percent of the patients interviewed had some form of voluntary health insurance. Fifty percent had Group Hospitalization (the equivalent of Blue Cross in the District of Columbia); in addition, about half of these had coverage with the Medical Service of the District of Columbia, which provides for surgical and medical benefits; 3 percent were covered by Blue Cross (not District of Columbia); 3 percent were members of Group Health Association; 17 percent subscribed to commercial insurance.

The actual cost to the patient varied according to the kind of health insurance he held. Those who subscribed only to group hospitalization had to pay about 60 percent of the total charge. Those who had Group Hospitalization plus Medical Service for surgical and obstetrical needs had to pay about 26 percent. Average payment of patients who belonged to various commercial plans was about two thirds of the total.

Of the 1796 patients observed 24 percent had family incomes of less than $3,000, 43 percent had incomes of from $3,000 to $5,000, 22 percent had incomes of from $5,000 to $7,500, and 11 percent had incomes of more than $7,500. This study indicated that family income had a definite relationship to membership in group insurance plans. People in the middle income range were more attracted to such plans. Those in the lower income group had a small membership, probably because the premium rates were too high for them, and those in the higher income group had a small membership, probably because they would not feel as acutely the need for such insurance. Therefore, members of the

high income group had greater total medical expenses because of the lack of insurance or because insurance gave only partial coverage and also because of the additional physician charges, and members of the lowest income group with no insurance also had larger bills than those in the middle income group who were covered by health insurance.

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This material is abstracted from "Costs of Hospitalized Acute Illness" by Theodore Wiprud and Isidore Altman, *JAMA*, November 4, 1950.

## PSYCHOLOGY AND THE ADOLESCENT

It is not surprising that adults find adolescents challenging and irritating, baffling and obvious, charming and crude, stimulating and dull, frustrating and gratifying. The normal adolescent at one time or another has any or all of these contradictory characteristics. He will remain so until he gives up the struggle and returns to a preadolescent psychological structure or finds an adult answer to his conflicts. The function of those working with and interested in the adolescent is to strengthen the forces leading to the latter solution.

1. The adolescent needs not only an opportunity to try out his newly found strength in new areas of independence but he also needs assurance and support. Therefore he needs someone upon whom he can be dependent if he becomes frightened but who will not demand that dependency as he becomes assured and safe.

2. It is important that adults realize the extreme sensitiveness of the adolescent. His many and often undirected responses should be met with casual although basically sympathetic tolerance.

3. His need to revolt and his anxiety over the implications of the revolt are difficult situations to handle wisely. He is not prepared to deal with the intensity of internal drives and the pressure of external demands without assistance. His experiences with freedom should be within a framework of wisely determined limits. These limits should be flexible, differing from individual to individual and from situation to situation. Rules are important if they strengthen the adolescent's impulse toward mature behavior rather than bind him to infancy.

4. Adolescents need a relationship with an adult who has handled relatively wisely his own maturation and who is sufficiently comfortable so that he will not fear to expose his own approach to life to the critical analysis of the young person.

5. Adolescents need parents. They may offer criticism of their parents and this frequently makes sense. The temptation to those working with the adolescent is to identify with him and reject the parents. This usually leads to one of two solutions. The adolescent may wish to abandon his parents but fears the step. Frightened by the stimulus from another person, the adolescent in acute anxiety reverts to greater dependency upon the parents to negate the temptation. On the other hand, too early encouragement of emancipation from the parents in minor details may mean encouragement to leave behind all that the parents stand for. Such abandonment is not safe except as new standards replace those of the parents. Adolescents must emancipate themselves from their parents and they need help in doing so, but the situation will be most constructively handled when the emancipation comes about through evolution rather than revolution.

6. Working with adolescents in groups rather than as individuals is the most fruitful point of focus for the support of adults. Group leadership that provides constructive patterns of behavior and a usable philosophy of life is the most constructive force for a normal adolescent.

Adolescents need support, encouragement, and guidance, but above all they need *time* before they are forced to crystalize their final pattern.

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From "Psychological Patterns of the Adolescent" by Irene M. Josselyn, M.D., in *Social Casework*, May and June, 1951.

## CONGENITAL SYPHILIS CASEFINDING AMONG SCHOOL CHILDREN

Effective control measures in venereal disease programs have resulted in a continuous

decrease in attack rate of acquired syphilis during these past five years. However, from morbidity reports compiled by the United States Public Health Service it seems that the incidence of congenital syphilis has remained somewhat unchanged during this same period of time. This indicates a need for greater effort in all activities having bearing on the prevention of congenital syphilis and early discovery of children with previously undetected congenital syphilis.

The nurse in a generalized public health nursing service is in a position to make a valuable contribution in the areas of prevention and early discovery of syphilis as she gives nursing service to pregnant women, infants, and children.

In considering some of the possibilities for finding syphilis among children the value of close dental inspection in combination with other nursing activities in the school program cannot be overlooked. Dental deformities are one of the most significant of the stigmata of congenital syphilis. Close cooperation between dentist, physician, and nurse within the school situation may lead to the initiation of casefinding procedures to uncover previously undetected congenital syphilis which may not be found in any other way in many children.

A survey was made in eighteen public schools for Negroes in Pemiscot County, Missouri, with the purpose of evaluating diagnoses of dental hypoplasias suggestive of congenital syphilis in relation to the actual presence or absence of the disease when substantiated by serologic tests for syphilis. The very high absentee rate, 38 percent of the total enrollment, suggested that congenital syphilis might be more prevalent in the absentee group than in the group inspected. The 1,639 children examined by the public health dentist included all who were present at school on the days of inspection and the siblings of those who were found to be infected with congenital syphilis. Findings showed that of fifty-four suspects reported by the dentist, fifty were serologically tested for syphilis and sixteen were found to be infected with congenital syphilis. Members of the family of each seropositive child were examined by the medical officer, and both mother and child were sent to the Midwestern Medical Center in St. Louis for final diagnosis and treatment. The authors believe this method of discovering cases of congenital syphilis would be most useful in areas of low prevalence where mass blood testing is not feasible. With little additional work dentists could make the names of persons with suspicious dental anomalies available to the venereal disease investigator.

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Abstracted from "Dental Hypoplasias in Relation to Congenital Syphilis" by Beecher, S. B., McIntosh, H. H., and McCart, E. J., in *Journal of Venereal Disease Information*, March 1951.

## HOW CHILDREN ACQUIRE MORALE

It is the job of adults to build morale and moral strength in children and thus prepare them for a happy life in the world in which they will live. To do this adults must have an understanding of themselves and of what they want for their children.

Only by gradual and continual guidance can a child develop morale, the capacity to think and act according to his own discrimination and choice. Children learn through day-by-day association with parents and teachers how to live. This method of teaching can do more to help prepare the child for life in a complex and changing world than simply teaching or moralizing or relying on the use of rewards and punishments, which are merely external aids in teaching.

To prepare children for the responsibilities that go with independence adults must point out the choices in life and teach them to appreciate the values involved. Children must also be taught to understand themselves and to evaluate their abilities, to take responsibility, and to cooperate and share with others. They should be encouraged to discuss problems with their parents and teachers.

In time of war with the threat of atomic attack the problem of instilling morale in children is even more difficult since tensions mount and fear is prevalent. Again the parent or teacher, equipped with the knowledge of what to do in case of emergency, must set the example. Not only must he teach civil de-

fense procedure, but he must also transmit the feeling of calm and confidence to the young ones who look to him for guidance.

The development of morale and moral strength in children demands more of the parent or teacher than it does of the child. If adults are to set good examples they must learn how to think and, consequently, to act according to these time-tested principles: "reverence for life, respect for persons and property, and love of truth and goodness."

Adults today often condemn young people for their lawlessness and lack of moral values. Their behavior is actually symptomatic of the insecurity and conflicts caused by world tensions which are keenly felt by children and youth. Adults could do a great deal to help young people overcome these feelings of fear and insecurity by teaching them to acquire morale.

Abstracted from "How Children Acquire Morale" by Algernon D. Black, *National Parent-Teacher*, September 1951.

## REINFECTION FOLLOWING THERAPY OF EARLY SYPHILIS

Vaughan in PUBLIC HEALTH NURSING, January 1951, in "Priorities for Public Health Nursing Visits" placed home visits to infants born of inadequately treated syphilitic mothers and contacts of known infectious primary and secondary syphilis in the category requiring home visits within twenty-four hours.

A visit made to a contact of a person with a diagnosis of early infectious syphilis or an infant born of a syphilitic mother is of greater health significance in health promotion and disease prevention than a visit to a contact of a person with late syphilis. This indicates a need for wise case selection before initiating epidemiology. Many health agencies have adopted field programs based on such criteria for case selection.

The importance of initiating epidemiologic procedures on individuals who, while presently cited as contacts of early infectious syphilis, had treatment under older methods of therapy, is sometimes not clearly understood. Confusion frequently arises when the cited contact is known to have had previous treatment, especially the older method of prolonged therapy.

It is well recognized that reinfections following rapid therapy of early syphilis are relatively frequent; however, the impression still persists that reinfections following the older methods of prolonged metal therapy were very rare. To prove that reinfections during prolonged treatment of early syphilis were extremely rare, but that they occurred much more frequently after the completion of treatment than was realized, the authors reviewed the records of about 8,000 patients who had been given some form of rapid treatment for early infectious syphilis. Records of 311 patients gave definite histories of previous antisyphilitic treatment with prolonged metal therapy. Of these 311, 215 were classified as reinfections, while the remaining ninety-six were classified as relapses. Of more interest than the number of probable reinfections after previous routine metal therapy was the duration of time between previous therapy and the development of new infectious lesions. All but thirty-two had received routine metal therapy more than two years prior to the appearance of new lesions. The time interval varied from less than one year to more than twenty-five years. The data reported prove that reinfections following prolonged metal therapy are not particularly rare and that some patients can be reinfected at any time after successful therapy.

Abstracted from "Reinfections Following Routine Metal Therapy of Early Syphilis" by Thomas, Evan W., and Landy, Simeon, in *Journal of Venereal Disease Information*, April 1951.

# NEW BOOKS
## And Other Publications

### HEALTH OBSERVATION OF SCHOOL CHILDREN

George M. Wheatley, M.D., M.P.H., and Grace T. Hallock. New York, McGraw-Hill Book Company, Inc., 1951. 491 p. $4.75.

The stated purpose of this book is to give background information to help teachers and others to observe and understand the school child in health and illness and to do this with a minimum of medical terminology and an avoidance of "teaching diagnosing." These worthy aims are attained and in addition a fascinating picture is presented of how children grow and develop, how healthy bodies and minds work, and how they defend themselves in adversity. Drama, an occasional flash of dignified humor, and whatever the student or teacher may want from the book are there to be found without too much searching.

The fields of physiology, anatomy, and hygiene are drawn upon for specific information to explain the subject under discussion and so also are psychology, sociology, economics, and even medical ethics. Scientific terms are used as needed and defined as they are used. There are charts, diagrams, illustrations, tables, and outlines to help the student accumulate as efficiently as possible the large mass of detailed information she will need as a teacher if she is to develop skill in recognizing deviations from health. This skill will be vital to her success in guarding as well as understanding her pupils. Each chapter closes with sections entitled: Do You Know, Suggested Activities, Selected References, and a list of government and national voluntary agencies offering materials on the topics discussed in the chapter. Although there is no attempt to impress the reader with how much more the authors know than they are telling there is an honest recognition that much more could be learned about many of the subjects and a healthy arousing of curiosity.

There is a careful avoidance of any sentimentality, but the child and his problems are presented in such a way that one feels how important the teacher is to the child's safety and happiness; that the teacher's opportunity to take part in school and community efforts to guide him safely through the various stages of normal development and vicissitudes is a privilege as well as a responsibility.

The book is attractively printed. References include classic ones as well as a good representation of current ones. The list of agencies with educational materials is well chosen, and there is a generous listing of motion pictures and film strips. However, the authors present a comprehensive rather than a selective list.

The nurse who is doing school work will recommend this book for inservice education of teachers. She will want at least one copy in the faculty reference library, and she will find her own desk copy useful in supplementing explanations to parents or older pupils by referring to some of the diagrammatic representations. It is safe to predict that teachers who use this reference will want to keep it on hand.

—MARIE SWANSON, R.N., *School Nursing Consultant,* NOPHN, *2 Park Avenue, New York 16.*

### COMMUNITY HEALTH EDUCATION IN ACTION

Raymond S. Patterson and Beryl J. Roberts. St. Louis 3, C. V. Mosby Company, 1951. 355 p. $4.50.

This book is for everybody concerned with community health education in both official and voluntary agencies—creating an awareness on the part of all public health workers

of the educational possibilities in every sort of health activity.

The first part is divided into three sections and deals with the philosophy of health education, organization of a community, and the hows and whys of learning. The second part, "from methods to mechanics," reviews the tools of health education but recognizes them for what they are—just tools. The type of print, construction of exhibits, writing of news articles, and other suggestions constantly being sought by health educators are presented. "Proof of the pudding," the third part, is a resumé of three going health education programs "lest the impression be gained that most of the foregoing discussions of principles and practices of community health education are the rather ethereal inventions of ivory-towered thinking."

Considerable essential information is given in a very entertaining style, and a helpful bibliography is included at the end of each chapter.

—Roslyn Rosen, R.N., *Connecticut Tuberculosis Association, Inc.*

**THE PUBLIC HEALTH NURSE AND HER PATIENT**

Ruth Gilbert, R.N., Cambridge, Harvard University Press, 1951. 2nd edition. 348 p. $3.75.

During the past eleven years public health nurses have developed more understanding of themselves; they have developed also a growing recognition of the individual's behavior in many life situations including the relationships with his family; and they have a greater understanding of how the nurse herself relates to an individual's behavior. Miss Gilbert's case-illustrated work-centered interpretations of public health nursing have contributed much to this understanding. The new revitalized edition of her book emphasizes the nurse's relationship to the individual within the family group. This book is not an attempt to influence a new philosophy of public health nursing, but seeks to enrich nursing service by giving it greater depth, accuracy, and vitality. It is interesting to note that this edition identifies the author as a nurse since she is now engaged in nursing education, in contrast to her former position as a psychiatric social work consultant in a public health nursing agency.

The format is much the same as in the first edition, but the sequence of chapters has been changed—"Teaching Health" following the introduction, "Mental Hygiene in Public Health Nursing." This sequence is logical because health teaching begins with a relationship between the nurse and the patient through the nurse's recognition and acceptance of the patient's problem and the way he feels about it. An interpretation is made of variations in relationships—the patient who accepts the nurse, the patient who is resistant to the nurse—and the projection of the nurse's standards upon the patient in these relationships.

Well defined approaches to problems help significantly; emphasis is placed on the processes of thinking the situation through, making selective observations of individuals and family groups, and on listening, responding, and recording as skills to be developed. The nurse's relationship with groups of individuals in health department services is discussed and amplified, and there is some interpretation of new methods in group education.

Many family illustrations are used throughout the chapters "Nurse and Maternity Patient," "The Child in His Family," and "Nursing the Sick Patient." Miss Gilbert presents real situations in relation to these services and interprets the changes and research in obstetrics, pediatrics, psychology, and psychiatry which influence these nursing services. Every experienced public health nurse has had similar patients and situations in her own experience, and one reads the book avidly, relating these descriptions of individuals and family situations to one's own experiences. Nurses will read this book with various purposes and feelings and with questions about their own activities.

It is well known that nurses have deep feelings about relations with other lay and professional workers in the health agencies and in the community which interfere with satisfying nursing services. It is regrettable that in the discussion of relations with coworkers further exploration and interpreta-

tion were not given to help nurses cope with problems and their own reactions and prejudices toward these coworkers.

This book is of value to all nurses and to other professional personnel in the health, welfare, and mental health services who are interested in learning about the services of public health nurses to the individual in his family and community. The extended bibliography of 108 references reveals the expanded social and scientific literature available to us.

—LILY C. HAGERMAN, R.N., *Mental Health Consultant, Public Health Service, Denver.*

### INTRODUCTION TO MOTHERHOOD

Grantly Dick Read, M.D. New York City, Harper and Brothers, 1950. 99 p. $1.75.

This is a very small book. The cover tells us that it is a "basic primer for the woman having her first baby, telling simply and exactly what to expect and how to prepare for natural childbirth." That summarizes the book in a nutshell. The basic principles are laid down with the simplicity of a master craftsman. There are those who will say it is too short, or that explanations are too meager, but if one thinks of a primer not as an elementary book, but as the fuse, the explosive, the catalyst which sets great forces in action, he will have the core of this book. It whets an appetite.

There are short paragraphs which hold much wisdom as in the plea for adequate nourishment in the first stage of labor. The chapter on labor has the old sure touch of authority. Particularly good is the stress on the four emotional menaces or hurdles of labor. Good, too, is the emphasis on the transition as a period of time between two stages and not as a stage of labor in itself. This one small point has caused much controversy and misunderstanding.

The discussion of the pelvic floor after delivery is one we would all do well to study. Its importance exceeds the one page devoted to it.

To those of us who see training for childbirth as a broad educational program leading to a happier, healthier, more secure family life, the last few pages on family relations are the cream of the book. The mother reading this book would do well to read this part first, to go back to it several times, and to take it to heart as a philosophy to live by.

—AILEEN HOGAN, R.N., *Maternity Center Association, New York City.*

### TEXAS NURSES IN REVIEW

Foundation for Research and Development in Health Activities, under the direction of Ross Garrett. Dallas, Foundation Press, 1951. 92 p. $10.00.

Sponsored by the Board of Nurse Examiners and based upon data secured by means of questionnaires answered by nearly 92 percent of currently registered nurses in the state (January-May 1951) the Texas report of a survey of nursing sources and resources is among the most recent of the twenty-five or more such state reports to be published. Like that of other states the story in the Texas report is by no means a happy one. As a matter of fact, the nursing situation revealed by the survey is referred to in terms of crisis or impending crisis. But the dashing appearance of the volume—its color, design, and styling—somewhat relieves the gloom of its message. So do the pungent phrases and nondefeatist tone of some of its recommendations.

The national nursing scene furnishes background for Texas facts and figures about nurses and nursing: number, distribution, type of work, age, marital status, schools from which graduated, and year of graduation. Present schools of nursing are described, and the recruitment, enrollment, and withdrawal of students are discussed. Public health nursing is not treated separately at any great length. It is stated that Texas must graduate 350 public health nurses and 100 public health nursing administrators a year to attain and maintain an adequate supply.

In the words of the author, as contained in the preface, the sole purpose of *Texas Nurses in Review* is "to provide basic information from which dynamic action may be crystallized by those in authority and by those providing leadership for Texas' destiny . . ."

It is dedicated to the governor of the state, members of the health team, and the people of Texas.

A special feature of the report is a detached "Suggestionnaire" form by means of which opportunity is provided readers to communicate their opinions to the Foundation for Research and Development in Health Activities which conducted the survey. Items upon which opinions are sought are public interest and action in nursepower deficiency problems, problems of recruiting and retaining student nurses, school standards and educational programs, making the best use of nursepower available by keeping it in Texas. A fifth item raises the question of whether the Foundation should publish recommendations and ways or means of improving the Texas nursepower situation, information about the new vocational nurse and technical nurse programs, and more information about diploma-degree and postgraduate programs in Texas.

—HORTENSE HILBERT, R.N., *Consultant, Special Project, National Committee for the Improvement of Nursing Services.*

### EDUCATION

AN EVALUATION OF THE TESTS OF GENERAL EDUCATIONAL DEVELOPMENT. Paul L. Dressel and John Schmid. Washington, American Council on Education. 1951. 57 p. $1.00.

### CHILD WELFARE

PROGRAMS OF THE FEDERAL GOVERNMENT AFFECTING CHILDREN AND YOUTH. Report of Interdepartmental Committee on Children and Youth. Washington, U. S. Government Printing Office. 1951. 126 p. 55c. Summary of what agencies in the federal government are doing for children and youth. A good reference, prepared originally as resource material for the Midcentury White House Conference.

### NURSING

MICROBIOLOGY AND PATHOLOGY FOR NURSES. Mary Elizabeth Morse, Martin Frobisher, Jr., Lucille Sommermeyer, and Raymond H. Goodale. Philadelphia, W. B. Saunders Company. Third edition. 1951. 815 p. $4.75.

LABORATORY EXERCISES AND OUTLINES IN MICROBIOLOGY FOR NURSES. Anne M. Fisher and Lucia Zylak. Philadelphia, J. B. Lippincott Company. 1951. 115 p. $3.00.

SOLUTIONS AND DOSAGE. Sara Jamison. New York, McGraw-Hill Company, Inc. Second edition. 1951. 163 p. $2.25.

ESSENTIALS OF PHARMACOLOGY AND MATERIA MEDICA FOR NURSES. Albert J. Gilbert and Selma Moody Brawner. St. Louis, The C. V. Mosby Company. Third edition. 1951. 343 p. $3.75.

MICROBIOLOGY FOR NURSES. Mary Elizabeth Morse, Martin Frobisher, Jr., and Lucille Sommermeyer. Philadelphia, W. B. Saunders Company. Eighth edition. 1951. 540 p. $4.00.

SIMPLIFIED NURSING. Florence Dakin and Ella M. Thompson. Philadelphia, J. B. Lippincott Company. 5th edition. 1951. 730 p. $4.00.

### MENTAL HEALTH

Two pamphlets for sale by the National Association for Mental Health, Inc., 1790 Broadway, New York 19. 1951. 15c each; discount on quantity orders.

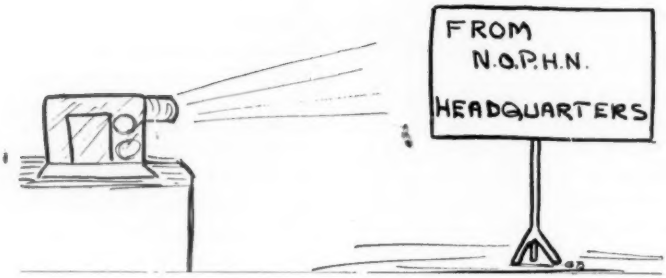
EATING PROBLEMS OF CHILDREN, a guide for parents, suggests how mothers can help their children develop good eating habits. It is reassuring, specific, and gives down-to-earth advice.

EATING PATTERNS OF CHILDREN, a guide for doctors and nurses, will be helpful to nurses in counseling parents and good for inservice education programs. Both pamphlets are charmingly illustrated.

ADVENTURE IN MENTAL HEALTH. Henry S. Maas, editor. New York, Columbia University Press. 1951. 333 p. $4.50. A report of military psychiatric social service for individual members of the Armed Forces in World War II, describing work in military prisons, psychiatric clinics, and hospitals, and the inherent implications for civilian practice.

A PRESS CONFERENCE ON THE EXCEPTIONAL CHILD. Proceedings of press conference held March 20, 1951, under auspices of the Child Research Clinic of the Woods Schools, for the purpose of reporting the latest scientific developments in the treatment of mental, physical, and emotional deviation in children. Free upon request from the Child Research Clinic of the Woods Schools, Langhorne, Pennsylvania.

LET'S LIVE. Claude Richards. New York, Exposition Press. 1951. 206 p. $3.00. Offers a constructive plan for better living which starts at home and extends into community, national, and international affairs.




### BIENNIAL CONVENTION

Have you marked your calendar and appointment book with the dates of the Biennial Nursing Convention to be held in Atlantic City—June 16-20, 1952? If not, do so *now*. Plans have been made for *advance registration by mail* in order to lessen the inconvenience of convention registration. Advance registration cards are being made available to members of the NOPHN, ANA, and NLNE.

The registration fee is $5.00 for all graduate registered nurses and lay members. Will you make your check or money order* payable to the 1952 Biennial Nursing Convention and mail your registration card and payment to 2 Park Avenue, New York 16, New York, in care of the Biennial Nursing Convention?

When your registration card and check are received at headquarters a receipt will be sent to you. This receipt must be presented at the Advance Registration Window in Convention Hall, Atlantic City, in order for you to obtain your convention badge which will admit you to meetings and exhibits. Be sure to bring your registration *receipt* and *membership cards* to the convention.

Advance registration closes on May 10, 1952. The usual provision for registration will be available in Convention Hall for those who do not find it convenient to register in advance; but if at all possible register in advance. It will eliminate a long wait in line in Atlantic City and give you a flying start for what is sure to be a thrilling week.

* Please do not include payment for other items in this check or money order.

### NEW BIBLIOGRAPHY

A new bibliography has been prepared on the "Administration of Voluntary and Governmental Payments for Medical Care." This replaces the earlier bibliography, "Medical Care and Nursing in Medical Care Plans." Order your copy from NOPHN, 2 Park Avenue, New York 16, New York. Price 15 cents.

### COLLEGIATE COUNCIL *PROCEEDINGS*

Mimeographed copies of the *Proceedings* of the work conference of the Collegiate Council on Public Health Nursing Education are now available from NOPHN at fifty cents a copy. (See PUBLIC HEALTH NURSING, December 1951, page 699, for an account of the conference.) The *Proceedings* contain the results of investigation undertaken by the various work groups at the conference. They include a review of similarities and differences in collegiate basic programs approved for public health nursing; an attempt to clarify some loosely-used terms in public health nursing education; some thoughts on the responsibilities of the beginning public health nurse working under supervision and on the broad educational experiences needed for developing these competencies; objectives and content of field instruction; ideas about aiding collegiate basic programs to achieve the characteristics necessary for accreditation for public health nursing.

### FOREIGN NURSES

For some time the NOPHN has been working closely with the ANA in planning programs for foreign nurses who come to the United States

for study or for a period of observation. At present Elizabeth Stobo sees all nurses from abroad who spend a day at national headquarters. She discusses the NOPHN program and services with them. If the visitor is interested in spending a short time observing in the field of public health nursing Miss Stobo makes arrangements for this. If the nurse is to be in the United States for six months or longer the ANA assumes the responsibility for arranging for her field activities. In these instances if the visitor is a public health nurse the NOPHN acts as consultant to the ANA staff member in planning for the experience the foreign nurse needs and wants in a public health nursing service.

In the period May 1-November 15, forty foreign visitors were seen at the NOPHN office. These came from nearby Canada, Central and South America, Europe, Africa, and Okinawa. The visitors from Okinawa were four physicians.

### REPRINTS AVAILABLE

The following reprints from the August, September, and October issues of the magazine are now available: "Admission and Discharge Conferences" by Edna Lake and C. L. Ianne, *free*; "Integration of Physical Therapy in a Generalized Public Health Nursing Program" by Marian H. Pratt, *free*; "Educational Planning by the Public Health Nurse" by Lucy C. Perry, 15 cents; "A VNA Considers Patients' Fees" by Emilie G. Sargent, 15 cents; "Community Planning and the Handicapped" by Sydney S. Norwick and Margaret Thomas, 10 cents; "The Public Health Nurse's Role in Feeding the Handicapped Child" by Ethel D. Patterson, 10 cents; "Raise Your Voice" by Elizabeth Reed, 15 cents; and "The Writing of Scientific Papers" by H. A. Davidson, 20 cents.

*One copy of each reprint may be secured free by* NOPHN *members.* Please order the Pratt, Norwick, and Patterson reprints directly from JONAS, 2 Park Avenue, New York 16, New York.

### ARTICLES ON STRUCTURE

"How Nonnurses and Agencies Will Participate in the NLA," originally planned for this issue, will be published next month. Other articles on structure, to be published in the future, will include questions and answers concerning points that seem to need further clarification; explanation of the additional recommendations, made by the Joint Coordinating Committee on Structure; and suggestions about how state units might study the national plan in relation to possible reorganization in the states after the 1952 Biennial Convention. The proposed bylaws for the new Nursing League of America and the proposed changes in the ANA bylaws will be published in April.

Reprints of the articles on structure, already published and of the article "How Nonnurses and Agencies Will Participate in the NLA," may be ordered from the ANA, NLNE, or NOPHN. Prices for the reprints are:

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| Single copies | $.10 |
| Sets of 5 articles: | |
| 1 to 9 sets | .35 |
| 10 to 24 sets | .33 |
| 25 to 99 sets | .31 |
| 100 or more sets | .30 |

A discount of 15 percent on orders for more than 100 sets is allowed to all constituent organizations.

### MEMBERSHIP NEWS NOTE

Congratulations are in order for agencies with 100% staff membership in the NOPHN for 1952. Here are first reports and we would like to add to the list. If your agency has 100% membership will you drop a line to the NOPHN membership secretary, Mrs. Marjory B. Hyde?

**IOWA**
Dubuque—City Health Department, Nursing Division

**MISSOURI**
St. Louis—Department of Public Welfare, Division of Health

**OHIO**
Cleveland—Visiting Nurse Association

And a cordial welcome to the following new life members:
Alice M. Dempsey, Boston, Mass.
Mrs. Mildred L. Ervin, Easton, Pa.
Mrs. Pearle Griffith Sadler, Washington, D. C.
Betty Sherwood, San Diego, Calif.

## ABOUT PEOPLE YOU KNOW

*Caroline E. Falls* retired in October as acting director of the Community Service Society, after nineteen years of service with the Society. Miss Falls was frequently loaned by the Society to fill a number of posts in professional organizations and health work, including the following: co-nursing adviser to Citizens Defense Nurse Corps, director of the defense program of NYSNA—both during World War II; instructor of the first advanced clinical course in psychiatric nursing at Teachers College, Columbia University. She expects to maintain an active interest in nursing and health work from her residence in Bethlehem, Connecticut. . . . The Department of State announces the appointment of *Bessie Marie Ball,* of Kansas City (Kansas) and Berea (Kentucky) for service in Nicaragua with a Point Four Health Program. . . . *L. Dorothy Carroll,* chief nursing consultant to the Communicable Disease Center, Public Health Service, FSA (Atlanta) is undertaking a three-month assignment for the Institute of Inter-American Affairs, a Point Four agency in Latin America. She will study public health nursing problems and facilities in communicable disease programs in Brazil in order to assist in establishing a training program. Miss Carroll will also visit Ecuador, Panama, and possibly other South and Central American republics to confer with local authorities on public health nursing problems in communicable disease. . . . *Marjorie W. Spaulding* is now regional public health nurse consultant in region VII (Kansas City, Missouri) Public Health Service. Miss Spaulding has been acting director of public health nursing in the North Dakota State Health Department . . . *Dr. Joseph W. Mountin* has been appointed chief of the Bureau of State Services, Public Health Service, succeeding *Dr. C. L. Williams,* who retired after serving as chief of the bureau for five years. . . . *Margaret Willhoit,* the first nurse assigned to Lebanon under the Point Four program, went to Beirut in November to set up and direct a graduate course in public health nursing at the American University of Beirut in its new School of Public Health and Preventive Medicine, the only one of its kind in the Middle East. The new school, organized under a Point Four grant, is training scholars from all the Arab countries. Miss Willhoit was in Athens for four years as chief nurse with ECA health mission.

*Madelyn N. Hall,* formerly executive director of the VNA of Plainfield (New Jersey) is now chief of Generalized Nursing Service in the Philadelphia Department of Public Health. . . . Ohio State University School of Nursing announces the appointment of *Mildred E. Newton,* formerly assistant dean of the University of California School of Nursing, as director of the School of Nursing and professor of nursing education. Other faculty appointments to the School of Nursing are *Florence M. Harvey, Ethel M. Leazenbee, Victoria Smith, Frieda Imogene Stewart, Helen R. Brown,* and *Yolan Ronai Guttman.* . . . *Mrs. Eugenie DeArmit Martensen* has been appointed assistant professor of public health nursing in the collegiate basic program at Florida State University.

## NOPHN FIELD SCHEDULE—DECEMBER

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| Ruth Fisher | Portland, Me. |
| Bessie Littman | Washington, D. C.<br>New Haven, Conn. |
| Eva M. Reese | Birmingham, Ala.<br>Gadsden, Ala.<br>Columbus, Ga.<br>Macon, Ga.<br>Savannah, Ga. |
| Judith E. Wallin | Ottawa, Ill.<br>Aurora, Ill.<br>Rockford, Ill.<br>Wilmette, Ill.<br>Winnetka, Ill.<br>La Grange, Ill.<br>Highland Park, Ill.<br>Evanston, Ill. |

November field trips not previously reported: Frances Goodman, Richmond, Va.; Eva M. Reese, Montgomery, Ala.

# NEWS AND VIEWS

## MANUAL ON MASS CARE IN DISASTER

Provision for medical and nursing care in shelters is a part of a new manual, *Mass Care in Disaster*, issued recently by the American National Red Cross to provide uniform instructions to assist chapters in planning for emergency care on a mass basis.

The section on medical and nursing services in shelters includes information on mobilization of the committee, assignment of personnel, medical inspections, accident prevention, emergency medical station, isolation room, infirmary, immunization, sanitation, and special facilities. It is pointed out that a nursing supervisor should be assigned to each shelter, with such additional nurses and auxiliary nursing personnel as may be required. The Red Cross deems it essential that registered professional nurses be assigned for twenty-four-hour coverage, either on a fulltime or visit basis.

The responsibilities of the nurse in charge are outlined and the manual also includes information on how Red Cross volunteer nurses aides and women who have completed the Red Cross home nursing course may be assigned to assist in shelters under the direct supervision of a professional nurse. Although designed primarily for use in natural disasters the information in this booklet can be adapted by chapters to any assignment civil defense authorities may give them for emergency relief or mass care. Write to ARC Headquarters, Washington, D. C., for copy. No charge.

## 1952 MARY M. ROBERTS FELLOWSHIP

The American Journal of Nursing Company announces that the third Roberts fellowship will be awarded in June 1952. This fellowship was established in 1950 to assist qualified professional nurses to prepare themselves in the aspects of writing about nursing and nursing education.

General professional qualifications and interest and facility in writing are considered by the Award Committee in its selection. A specially prepared manuscript on some subject pertaining to nursing must be submitted by each competitor. A sum of from $2,000 to $4,000 is awarded to the winning candidate for one academic year of study in a college or university.

The competition is open to all graduate professional nurses. The final date for submitting credentials, including the manuscript, is February 15, 1952. The name of the winner will be announced by June 1, 1952.

## GLAUCOMA

A pamphlet published by the National Society for the Prevention of Blindness, *Glaucoma*, points out that the best defense against this disease is a thorough eye examination at least once every two years for people over forty, since it is difficult to detect in the early stages and usually can be checked if caught early. This pamphlet is available without charge from NSPB, 1790 Broadway, New York 19.

## AID TO PRACTICAL NURSE TRAINING

The W. K. Kellogg Foundation has announced grants totaling about $750,000 to aid the development of practical nurse training in five states over a three-year period. The funds will be used to assist one or more existing centers and to help establish new centers, the program to be conducted by the state departments of education in cooperation with local agencies. Extension training will be conducted for individuals now serving as practical nurses.

Alabama, Arkansas, and Louisiana have

already received their initial installments, Florida has been tentatively approved, and negotiations are in progress with Mississippi. The states are expected to contribute about $580,000 to the program. These grants are an extension on a national scale of the practical nurse training program begun in Michigan in 1947.

### CERTIFICATION IN CALIFORNIA

At its September 1951 meeting the California State Board of Health revised the regulations governing the issuing of the state public health nursing certificate. As a result of this action the California public health nursing certificate will be issued *after* January 1, 1954, only to nurses who have completed a university program accredited for public health nursing.* Until that date applicants will be able to qualify for the state certificate either by completion of a university program approved for public health nursing or on the basis of completion of twelve units of university work, two years of public health nursing experience, and passing an examination.

Further information about the revision of the regulations may be obtained from the Bureau of Public Health Nursing, California State Department of Public Health, Room 751, Phelan Building, San Francisco 2, California.

* There are two categories of educational programs preparing nurses for beginning public health nurse positions in public health nursing services: (1) a collegiate basic nursing program approved for public health nursing by NNAS (2) a program for graduate nurses leading to a baccalaureate or higher degree with a major in public health nursing approved by NNAS.

### NURSING RESEARCH

To meet the fast expanding need for the prompter, more constructive use of the results of scientific studies of nursing problems this new digest-size magazine will feature previously unpublished materials which embody new concepts or new findings in areas where more facts are especially needed.

It will provide detailed analyses of the results of recently completed work, abstracts of other relevant data, reports covering undertakings still in progress, and it will place special emphasis on pilot studies which advance the frontiers of nursing knowledge.

Sponsored by the Association of Collegiate Schools of Nursing, endorsed by all the national nursing organizations and employing the publishing facilities of the American Journal of Nursing, *Nursing Research* will be published three times a year. The first issue is scheduled for publication in June 1952. The price will be $2.50 a year.

### GUIDE FOR PARENTS OF CHILDREN WITH RHEUMATIC FEVER

*If Your Child Has Rheumatic Fever,* published recently by the Massachusetts Heart Association, replaces a shorter booklet published by the association, *Short Lessons for "Rheumatic" Families.* The new guide offers practical suggestions about the disease on things to do to prevent recurrences, danger signals to be on the lookout for, treatment procedures, and so forth. The summary is an admirable "refresher" course. Dr. Ernest Craige of Harvard Medical School and Massachusetts General Hospital is the author and illustrator. Distributed by the Massachusetts Heart Association, 650 Beacon Street, Boston 15.

### PROGRAM FOR THE RURAL MOTHER

The Medical Mission Sisters' Catholic Maternity Institute in Santa Fe, New Mexico, has opened an annex with a new feature. The annex consists of three private apartments where the expectant mother and a relative may live during the period of confinement. The opening of this center gives women who live beyond the thirty-mile limit which the Sisters normally cover the opportunity to be assisted by a prepared nurse midwife during delivery. (See "Birthday in Cerrillos" by Sister M. Roberta in PUBLIC HEALTH NURSING, August 1951, for an account of the work of the Catholic Maternity Institute.)

### FIELD PRACTICE

A study carried out by Catherine B. Glennon at Indiana University on "Policies Relative to Student Field Practice in Educational Programs for the Preparation of Public Health

Staff Nurses" is now available. This study was initially undertaken because of the need to set up criteria for evaluating work experiences of students who enrolled in the Division of Nursing Education at the university.

Copies of the study may be purchased from the Indiana University Bookstore, Bloomington, Indiana. Price, $2.50.

### EMPLOYMENT OF ADOLESCENTS IN INDUSTRY

A statement issued by a subcommittee of the Council on Industrial Health of the American Medical Association points out that the number of minors fourteen to eighteen years of age employed in nonagricultural pursuits has continued to rise significantly during the past decade; that there are two million fewer young persons today than there were in 1940; that the potential of youth population will reach its lowest point in 1952 and will not increase to any extent until 1958. The subcommittee urges that the child labor and youth employment standards recommended by the National Child Labor Committee be accepted during the present emergency, in order to insure optimum health and training for our future manpower reserves.

The complete statement may be obtained by writing to the National Child Labor Committee, 419 Fourth Avenue, New York 16.

### THE PLACE OF THE NURSE IN INDUSTRY

A short report prepared by the Industrial Nurses Section of the Pennsylvania SNA lists ten statements of policy to serve as a guide to the nurse and management in providing working relationships which are basic to a sound health program. A compact industrial nursing bibliography is included. Write to PSNA, 2515 North Front Street, Harrisburg, for a copy.

### EQUAL PAY

The Regional Wage Stabilization Board at Denver has announced the unanimous adoption of a resolution recognizing equal pay for comparable work regardless of sex. This is the first policy, regional or national, regarding equal pay to be adopted under the current wage stabilization program.

● The Communicable Disease Center, Public Health Service, Federal Security Agency, Atlanta, Georgia, has announced that the spring Field Training Course in Epidemiology for Public Health Nurses will start May 12, 1952. The course is designed to give public health nurses a broader understanding of presentday communicable disease problems and their control. The knowledge and skills necessary for field investigations of major communicable diseases and disease outbreaks will be emphasized. Field experience in communicable disease investigations will be available to a limited number of students.

There is no charge for the course but nurses will be expected to pay their own living and traveling expenses. Public health nursing supervisors, educational directors, coordinators, well qualified public health staff nurses, communicable disease consultants, nurse epidemiologists, and communicable disease nursing instructors in schools of nursing recommended by their state public health nursing director or an appropriate federal official are eligible.

For application and further information write to the Medical Director in Charge, Communicable Disease Center, Atlanta, Georgia.

## Staff Evaluation

*(Continued from page 35)*

formance is now under way. New problems, new disagreements, and new discouragement have been met and dealt with. Several technics have been tried and discarded. A natural desire to finish this task quickly now, after spending a year on the first half, has given way to a recognition that the purpose will be lost unless the same full, free participation goes into this part as that which went into the analysis and organization of tasks. Many of the experiences described above have been repeated and the group has again settled down to a year of difficult but satisfying work. We have no doubt that it will be carried through with increasing rather than waning interest.

The project itself is proving to be the Pow'r that will give the gift of the ability to see ourselves as others see us.

# OFFICIAL DIRECTORY OF PUBLIC HEALTH NURSING

*A list of those holding executive positions in the federal government, in national organizations, and in states and territories; officers of state organizations for public health nursing, and executive secretaries of state nurses associations*

Information as of December 1, 1951, unless otherwise stated.

**International Council of Nurses (with which is associated the Florence Nightingale International Foundation).** 19 Queen's Gate, London S. W. 7, England.
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Executive Secretary, Daisy C. Bridges, 19 Queen's Gate, London S. W. 7, England.
ANA Committee on the FNIF, Chm., Lulu K. Wolf, University of California School of Nursing, Los Angeles 24, California

**National Organization for Public Health Nursing, Inc.**
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General Director, Anna Fillmore, 2 Park Avenue, New York 16, N. Y.

**American Association of Industrial Nurses**
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Executive Secretary, Mrs. Gladys L. Dundore, Room 909, 654 Madison Avenue, New York 21, N. Y.

**American Nurses Association**
President, Mrs. Elizabeth K. Porter, Frances Payne Bolton School, Western Reserve University, 2063 Adelbert Road, Cleveland 6, Ohio
Executive Secretary, Ella G. Best, 2 Park Avenue, New York 16, N. Y.

**Association of Collegiate Schools of Nursing**
President, Elizabeth S. Bixler, Yale School of Nursing, 310 Cedar Street, New Haven, Connecticut

**National League of Nursing Education**
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**Joint Board of Directors of the Six National Nursing Organizations,** 2 Park Avenue, New York 16, N. Y.
Chairman, Agnes Gelinas

**Joint Coordinating Committee on Structure,** 2 Park Avenue, New York 16, N. Y.
Chairman, Pearl McIver

**National Nursing Accrediting Service,** 2 Park Avenue, New York 16, N. Y.
Director, Helen Nahm

**National Committee for the Improvement of Nursing Services,** 2 Park Avenue, New York 16, N. Y.
Director of Programs, Marion W. Sheahan

**Committee on Careers in Nursing,** 2 Park Avenue, New York 16, N. Y.
Director of Public Relations, Mrs. Muriel C. Henry

**National Association for Practical Nurse Education,** 654 Madison Avenue, New York 21, N. Y.
President, Mrs. Mildred L. Bradshaw
Executive Secretary, Hilda M. Torrup

**National Federation of Licensed Practical Nurses,** 250 West 57 Street, New York 19, N. Y.
President, Mrs. Lillian E. Kuster

**Federal Civil Defense Administration, Health and Special Weapons Defense Division,** Washington 25, D.C.
Nursing Consultant, Frances Crouch Nabbe

**American National Red Cross, Nursing Services,** National Headquarters, Washington 13, D.C.
National Director, Ann Magnussen
Assistant National Director, Lona L. Trott
Disaster Nursing and Nurse Enrollment, Virginia B. Elliman
Home Nursing and Nurse's Aide Instruction, Olivia T. Peterson
Nursing Projects, Eula B. Butzerin
Blood Program, Evelyn T. Stotz

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Jeanie L. Adkerson, Director, Nursing Service
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Kathryn Fitzpatrick, Director, Nursing Service
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Irene Thompson, Director, Nursing Service

**Army Nurse Corps**
Chief, Col. Ruby F. Bryant, Nursing Division, Office of The Surgeon General, U. S. Army, Main Navy Building, Washington 25, D.C.

**Navy Nurse Corps**
Director, Captain Winnie Gibson, Potomac Annex, Navy Department, Washington 25, D.C.

**Air Force Nurse Corps**
Chief, Col. Verena M. Zeller, Office of The Surgeon General, U. S. Air Force, Washington 25, D.C.

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Consultant in Hospital Nursing, Mary E. Gahagan, Bureau of Indian Affairs, Washington 25, D.C.

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**U. S. Department of State**
Mrs. Maxine T. Smith, Chief Nurse

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Ruth G. Taylor, Chief, *Nursing Section*
Alice F. Brackett, Assistant Chief, *Nursing Section*
Ruth Doran, Special Consultant in Nurse Midwifery and Maternity Nursing

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*Office of the Surgeon General*
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*Bureau of Medical Services,* Federal Security Building South, 4 and C Streets, S.W., Washington 25, D.C.
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Assistant Chief, Margaret McLaughlin
Director of Studies, Marion Ferguson
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Division of Occupational Health, Chief Nursing Consultant, Winifred Devlin
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*Clinical Center*
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Hospital Inspection Section, Consultant in Psychiatric Nursing, Mary E. Corcoran
Training and Standards Branch, Consultant in Psychiatric Nursing Education, Esther Garrison
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*National Cancer Institute*
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**MAINE**
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**State Department of Health**—Vera D. Knickerbocker, Director, Division of Public Health Nursing, Bismarck
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**State Department of Public Instruction**—Mildred S. Coyle, School Nursing Adviser, Harrisburg
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**PUERTO RICO**
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**Puerto Rico Nurses Association Secretary**—Carmen L. Rivera, Box 1814, San Juan

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**State Organization for Public Health Nursing**—President, Helen Prince, 4 Baptist Street, Pawtucket. Secretary, Mary L. Kennedy, City Health Department, Providence
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**State Department of Health**—Alice B. Olson, Director, Division of Public Health Nursing, Pierre
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**TENNESSEE**
**State Department of Public Health**—Frances F. Hagar, Director of Public Health Nursing, Division of Local Health Service, Nashville 3
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**State Department of Health**—Mildred Garrett, Director, Division of Public Health Nursing, Austin
**State Nurses Association General Secretary**—A. Louise Dietrich, 1001 E. Nevada Street, El Paso

**UTAH**
**State Department of Health**—Evelyn Kidneigh, Director, Division of Public Health Nursing, Salt Lake City
**State Nurses Association Executive Secretary**—Mrs. E. G. Richards, 158 E. 2 Street, Salt Lake City

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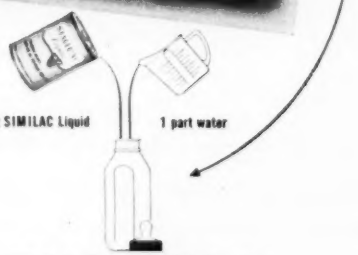


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1. Stearns, G. Human requirements of calcium, phosphorus, magnesium. J. Am. Med. Assn. *142*:478 (Feb.) 1950.
2. Smith, J. M. Calcium needs of teen-age boys. Nutrition News, (April), 1947.


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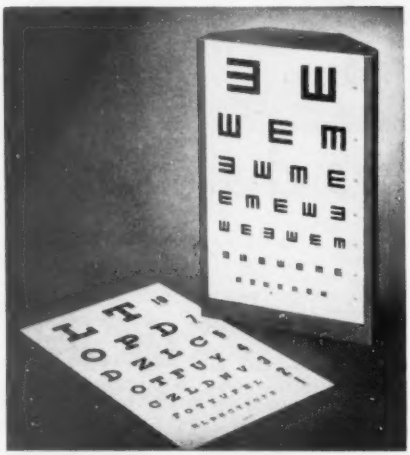

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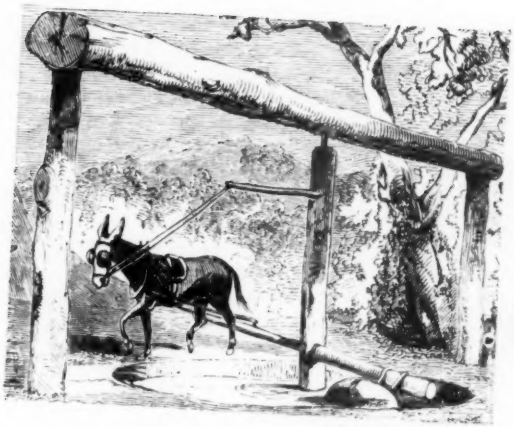

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1. Behrman, H. T., Combes, F. C., Bobroff, A., Leviticus, R.: Ind. Med. & Surg. 18:512, 1949.
2. Turell, R.: New York St. J.M. 50:2282, 1950.
3. Heimer, C. B., Grayzel, H. G., and Kramer B.: Archives Pediat. 68:382, 1951.

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